

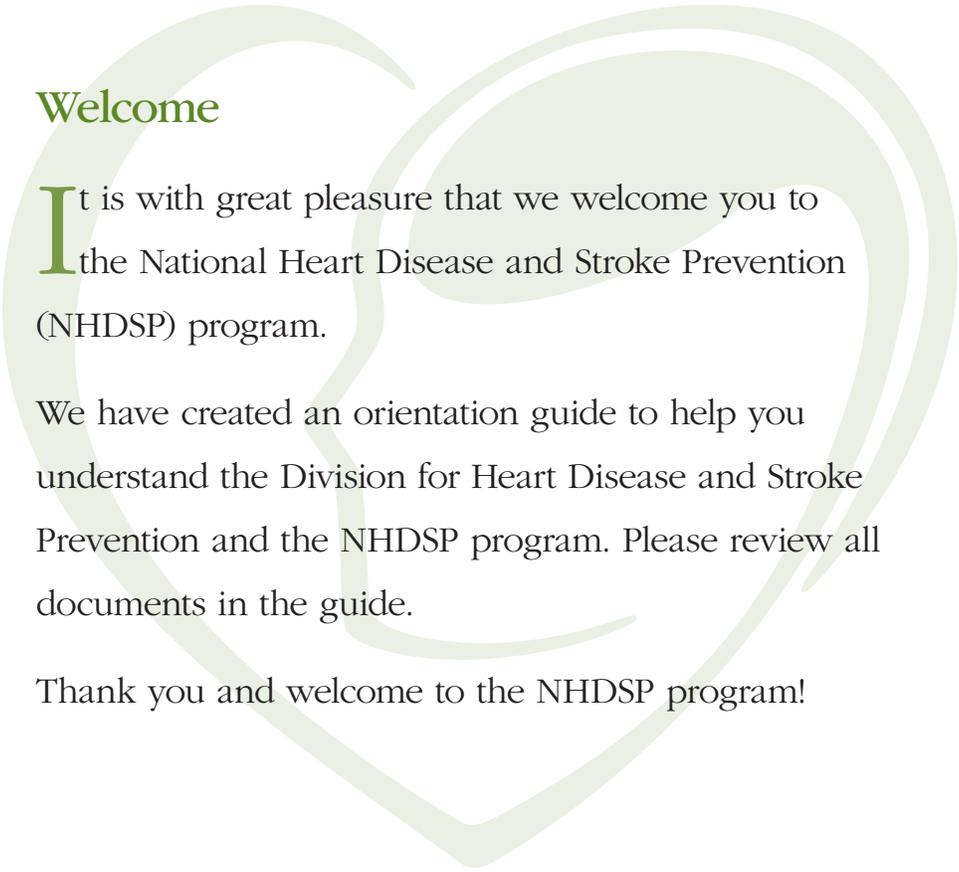
National Heart Disease  
and Stroke Prevention Program

# Staff Orientation. guide

September 2011

National Center for Chronic Disease Prevention and Health Promotion  
Division for Heart Disease and Stroke Prevention





## Welcome

**I**t is with great pleasure that we welcome you to the National Heart Disease and Stroke Prevention (NHDSP) program.

We have created an orientation guide to help you understand the Division for Heart Disease and Stroke Prevention and the NHDSP program. Please review all documents in the guide.

Thank you and welcome to the NHDSP program!

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DIVISION FOR HEART DISEASE AND STROKE PREVENTION

# Background and Overview

## The Burden of Heart Disease and Stroke

Heart disease and stroke, the first and third leading causes of death for men and women, are among the most widespread and costly health problems facing our nation today. An estimated 935,000 heart attacks and 795,000 strokes occur each year. One in four deaths is caused by heart disease, and someone dies of a stroke on average every four minutes. Heart disease and stroke also are among the leading causes of disability in the United States. Nearly 4 million people report disability from these causes.

Death rates alone cannot describe the burden of heart disease and stroke. In 2010, the total costs of cardiovascular diseases, which include heart disease and stroke, were estimated to be \$444 billion. Treatment of these diseases accounts for about \$1 of every \$6 spent on health care in this country. As the U.S. population ages, the economic impact of cardiovascular diseases on our nation's health care system will become even greater.

Overall, death rates for heart disease and stroke have decreased in the United States in recent decades. However, rates for incidence and death continue to be high, especially among some populations, including members of certain racial and ethnic groups, people with low socioeconomic status, and those living in the southeastern United States. For example, the risk of having a first-ever stroke is nearly two times higher among African Americans than among whites. In addition, about 55,000 more women than men have a stroke each year. Recent studies show that the prevalence of heart disease and the percentage of associated premature deaths are higher among American Indians and Alaska Natives than among any other U.S. racial or ethnic group.

The news is not all bad, however. Scientific evidence confirms that many lives can be saved through prevention and early detection. The prevention of

cardiovascular diseases also results in significant savings of our nation's limited health care resources. CDC's Division for Heart Disease and Stroke Prevention (DHDSPP) is committed to having a positive impact on cardiovascular diseases.

## The Division for Heart Disease and Stroke Prevention

CDC has engaged in heart disease and stroke prevention work since the late 1980s, beginning with the emergence of the Cardiovascular Health Studies (CVH) Branch in the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). In 1998, CDC and the National Institutes of Health were named co-leaders of the Healthy People 2010 objectives for heart disease and stroke. In that same year, Congress funded CDC to establish the National Heart Disease and Stroke Prevention Program, which helps build state- and local-level comprehensive heart disease and stroke programs. In 2001, following the death of Senator Paul Coverdell from a stroke, Congress funded CDC to establish state stroke registries to capture data that can be used to measure and improve the quality of acute stroke care.

In 2006, CDC established DHDSPP as one of 10 stand-alone divisions within NCCDPHP. DHDSPP was created by combining the CVH Branch, the WISEWOMAN program, and the office of the Division of Adult and Community Health's Associate Director for CVH Policy and Research. WISEWOMAN provides uninsured women aged 40–64 with access to screening, referral, and lifestyle interventions to help reduce their risk for heart disease and other chronic diseases.

DHDSPP's mission is to be the nation's public health leader for achieving cardiovascular health for all and reducing the burden of disparities in heart disease

and stroke. DHDSP staff collaborate with national public- and private-sector partners to plan, direct, and coordinate programs and research that reduce risk factors, disease, deaths, and disparities associated with heart disease and stroke.

DHDSP provides national leadership in addressing key issues, such as sodium consumption, awareness of signs and symptoms of heart attack and stroke, and access to screening and interventions for cardiovascular problems. The results of DHDSP's work are often highlighted in the national media, have gained widespread exposure on the Internet, and have been published in professional and peer-reviewed journals and publications.

## The National Forum for Heart Disease and Stroke Prevention

CDC, the American Heart Association, and the Association of State and Territorial Health Officials led the development of the landmark publication *A Public Health Action Plan to Prevent Heart Disease and Stroke* (Action Plan). The National Forum for Heart Disease and Stroke Prevention was convened to review draft recommendations for the Action Plan in September 2002, and in 2003 it became a major vehicle for implementing the plan. This national coalition, now representing more than 80 organizations, provides strategic guidance on heart disease and stroke prevention activities through the Action Plan and promotes collaboration through an annual meeting held in Washington, D.C., and face-to-face meetings with each of its seven implementation work groups. The Action Plan provides states, organizations, and key stakeholders with a framework for planning public health strategies to prevent heart disease and stroke throughout the nation.

## DHDSP Goals

1. Prevent risk factors for heart disease and stroke.
2. Increase detection and treatment of risk factors for heart disease and stroke.
3. Increase early identification and treatment of heart disease and stroke.
4. Decrease recurrences of cardiovascular events.
5. Foster a skilled and engaged public health workforce to address heart disease and stroke.

## Organization and Staffing

### DHDSP Structure

DHDSP consists of the Office of the Director (OD) and three branches: the Applied Research and Evaluation Branch (AREB), the Epidemiology and Surveillance Branch (ESB), and the Program Development and Services Branch (PDSB).

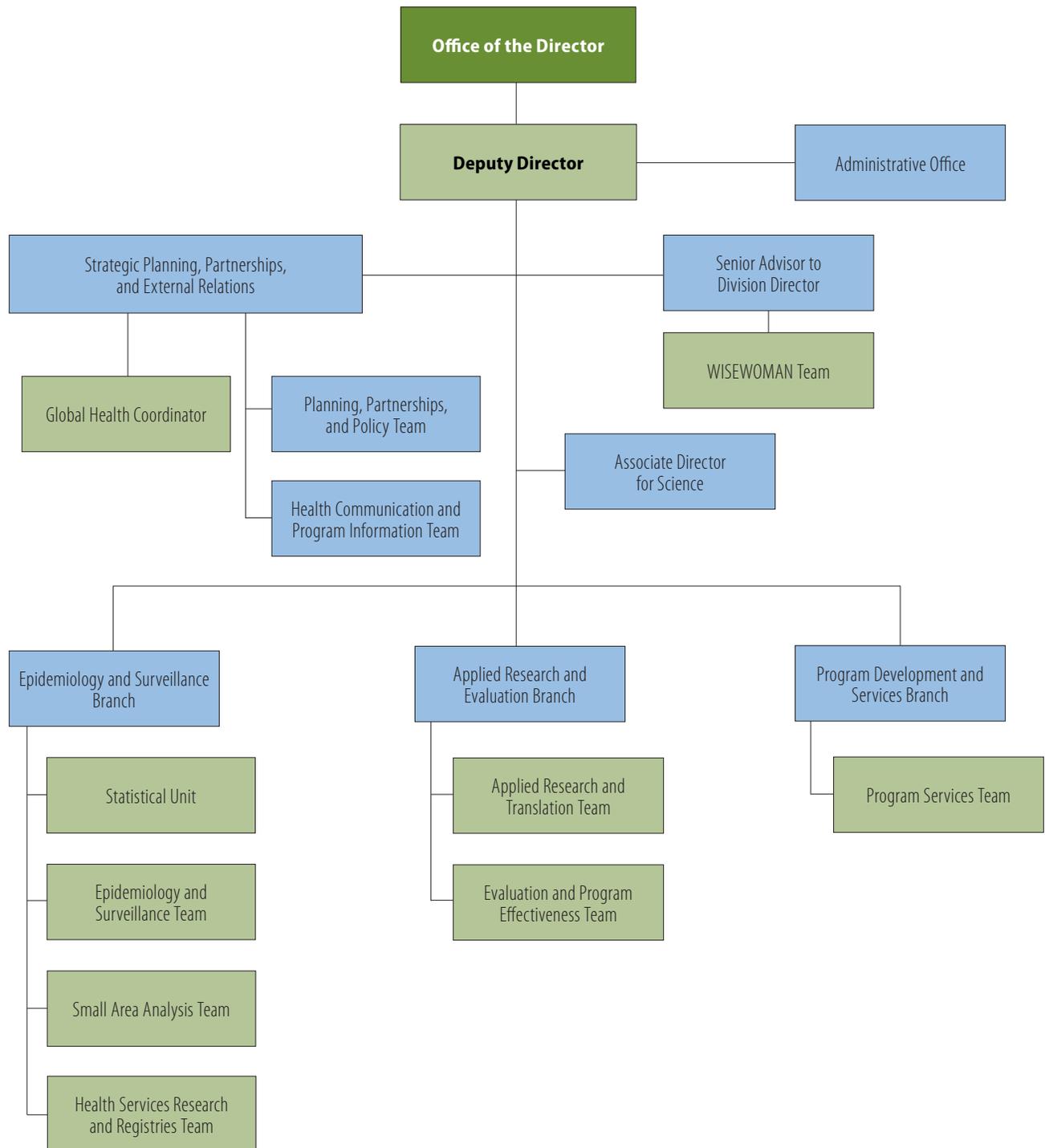
### Office of the Director

OD is responsible for resource management, research coordination, communications, partnership building, external affairs, coordination of policy and legislative activities, and global collaborations. OD staff participate in and manage activities related to Division partnerships, such as CDC's Cardiovascular Health Collaboration, the National Forum, and the Healthy People 2010 Partnership.

### Program Development and Services Branch

PDSB promotes evidence-based strategies and programs to reduce health disparities and prevent heart disease and stroke throughout the nation. It funds and manages cooperative agreements with states, tribal organizations, and partners and provides technical assistance to staff in the National Heart Disease and Stroke Prevention Program. PDSB

## DHDSP Organizational Structure



provides grantees with comprehensive technical assistance, training, and programmatic tools and guidance for the development, implementation, and evaluation of programs. Together with related programs across NCCDPHP, PDSB provides leadership to ensure collaboration that can affect heart disease and stroke prevention outcomes.

### Epidemiology and Surveillance Branch

ESB studies patterns and trends in the following areas as they relate to cardiovascular diseases: risk factors, costs, health behaviors and outcomes, barriers to patient access to care, public awareness, geographic variation, and disparity of cardiovascular disease rates among races and ethnic groups. These scientific findings allow DHDSP and its partners to respond to emerging health risks and promote public health practice. ESB funds and manages the Paul Coverdell National Acute Stroke Registry. Staff provide technical assistance and expertise through scientific articles, research findings, geographic information system mapping, and promotion of new surveillance methods and technologies.

### Applied Research and Evaluation Branch

AREB works with states, partners, and colleagues to conduct and translate applied research and evaluation of heart disease and stroke prevention efforts. It evaluates programs, policies, and interventions to ensure they are working as planned and producing the intended results. It promotes evidence-based practice by translating scientific findings into practical resources and tools for public health practitioners, health care providers, and others working to prevent heart disease and stroke. In addition, AREB supports state program activities through technical assistance, guidance, resource development, and capacity building for applied research and evaluation.

## Funded Programs

DHDSP funds and supports three national heart disease and stroke prevention programs. The fiscal year 2010 appropriation was \$56 million for heart disease and stroke prevention programs. Funds are awarded through a competitive process for the National Heart Disease and Stroke Prevention Program, Paul Coverdell National Acute Stroke Registry, and Sodium Reduction in Communities Program.

### National Heart Disease and Stroke Prevention Program

The National Heart Disease and Stroke Prevention Program provides funding and support to state health departments to manage heart disease and stroke prevention programs at the state and local levels. DHDSP shares the latest science and practices with states to help reduce disease, deaths, and health disparities related to heart disease and stroke, especially among those at high risk. The program has grown from funding 8 states in 1998 to funding 41 states and the District of Columbia in the current funding cycle. Twenty-eight states are funded for capacity building and 14 for basic implementation.

CDC-funded state programs promote changes to policies and systems in health care, worksite, and community settings and the elimination of health disparities by emphasizing the ABCS of heart disease and stroke prevention. Some programs also work to improve emergency response and quality of acute care.

### WISEWOMAN

The Well-Integrated Screening and Evaluation for WOMen Across the Nation (WISEWOMAN) Program helps women with little or no health insurance access services that can help reduce their risk for heart disease, stroke, and other chronic diseases. The priority age group is women aged 40–64 years.



departments in Georgia, Massachusetts, Michigan, Minnesota, Ohio, and North Carolina. In 2007, CDC, The Joint Commission's Primary Stroke Center Certification program, and the American Heart Association/American Stroke Association's Get With The Guidelines®-Stroke program jointly released a set of standardized stroke performance measures to be used by all three programs. This effort has reduced duplication of effort, increased collaboration, and encouraged hospitals to participate in the programs.

## Office of the Director

### Mississippi Delta Health Collaborative (Delta Health Initiative)

The Mississippi Delta Health Collaborative (MDHC) is designed to prevent heart disease, stroke, and related chronic diseases. Through a new five-year cooperative agreement, this initiative will intensify collaboration among the Mississippi Department of Health, existing chronic disease programs (e.g., heart disease and stroke prevention, diabetes, tobacco, nutrition, physical activity), local health departments, other community health care providers (e.g., federally qualified health centers), local communities, and CDC. This result will be achieved through implementation of interventions across Mississippi's 18-county Delta Region. The program will target the **"ABCS"** of heart disease and stroke prevention among priority populations in high burden, underserved, rural areas:

- **Aspirin:** Increase low-dose aspirin therapy according to recognized guidelines.
- Hemoglobin **A1c** (HbA1c): Monitor and control blood glucose.
- **Blood pressure:** Prevent and control high blood pressure.
- **Cholesterol:** Prevent and control high LDL-cholesterol.
- **Smoking:** Prevent initiation and increase cessation of smoking, and increase the percentage of the population protected by smoke-free air laws or regulations.

The Mississippi Department of Health will provide leadership and funding support in the Delta Region to implement prioritized population-based interventions: policy, systems, and environmental change selected as appropriate from a set of prescribed evidence-based strategies in both the clinical and community settings.

### WISEWOMAN

The WISEWOMAN Program began a new five-year funding cycle June 30, 2008. The competitive application process resulted in 21 programs being funded. This is an increase of six programs from the previous funding cycle. Seventeen WISEWOMAN programs also receive funding to implement the National Heart Disease and Stroke Prevention Program.

One major focus of the funding opportunity announcement (FOA) is development of partnerships. At a minimum, funded programs are expected to partner with their state/tribal Breast and Cervical Cancer Early Detection Program, Tobacco Control Program, Heart Disease and Stroke Prevention Program/Coalition, and other programs that can affect policies and environments in which WISEWOMAN participants live, work, and play. Because the majority of WISEWOMAN funding must be spent on providing direct services to women, partnerships are extremely important to ensure participant access to affordable and quality resources to support heart health.

WISEWOMAN evaluation emphasizes program improvement and is based on the CDC Framework for Program Evaluation in Public Health. CDC has developed key evaluation questions related to the program's stated goals and logic model components.

The questions are used in the evaluation of the WISEWOMAN Program. Funded programs are required to conduct evaluations to assess progress toward meeting stated work plan objectives and to share results with others, including their providers, partners, other stakeholders, and CDC. Funded programs contribute to the WISEWOMAN Program evaluation by providing Minimum Data Elements data, submitting information to CDC that supports program evaluation activities, and participating in activities such as site visits and case studies.

### Sodium Reduction in Communities

High sodium consumption is a major contributor to high blood pressure, a leading cause of stroke, coronary heart disease, heart attack, and heart and kidney failure in the United States. The 2010 *Dietary Guidelines for Americans* recommend limiting sodium to less than 2,300 milligrams (mg) per day. Individuals who are 51 and older and those of any age who are African American or have hypertension, diabetes, or chronic kidney disease should limit intake to 1,500 mg of sodium per day. These groups account for about half the U.S. population and the majority of adults.

Studies show that, on average, U.S. adults consume more than 3,400 mg of sodium per day. An estimated 77 percent of sodium comes from processed and restaurant foods. Reducing dietary intake of sodium to 2,300 mg per day could prevent as many as 11 million cases of hypertension in the United States. Further reductions in sodium intake to 1,500 mg per day could prevent more than 16 million cases.

Through the three-year Sodium Reduction in Communities cooperative agreement, which began in September 2010, DHDSP is providing support to six communities to support policy changes designed to create healthier food environments. The communities receiving support include California (Shasta County),

Kansas (Shawnee County), Los Angeles County, New York City, and New York State (Broome and Schenectady counties).

## Program Development and Services Branch

### Funded State Programs

#### **National Heart Disease and Stroke Prevention Program:**

The enhanced reach of the National Heart Disease and Stroke Prevention Program was a key accomplishment in 2008. Eight new states (Connecticut, Hawaii, Idaho, Iowa, Maryland, New Jersey, North Dakota, and West Virginia) were funded as part of the program, bringing the total number of funded programs to 42.

**Leadership to Center Integration:** PDSB has provided leadership to NCCDPHP's initiative to increase synergy, reach, and desired health outcomes in selected NCCDPHP-funded categorical programs (National Heart Disease and Stroke Prevention; Diabetes Prevention and Control; Tobacco Control; Comprehensive Cancer Control; Nutrition, Physical Activity, and Obesity; and the Behavioral Risk Factor Surveillance System).

**National Training:** DHDSP conducted the 2008 National Heart Disease and Stroke Prevention Training Institute on September 9–11 in Atlanta. The training focused on longer, skill-building, interactive workshops that addressed the competencies, program priorities, and performance measures of the FOAs for DHDSP's funded programs. It included the National Heart Disease and Stroke Prevention Program and WISEWOMAN and was expanded to include representation from each state's heart disease program as well as American Heart Association field staff working in the states. Informal feedback indicates that the training has already led to greater collaboration at the state level.

**Management Information System (MIS):** In 2008, DHDSPP completed revisions for the heart disease and stroke prevention Web-based MIS. The report generated by the system was changed to a table that displays an objective time frame, status, and progress in an easy-to-read format. These changes made the system more user friendly for states and CDC. The MIS can now be used to:

- Describe state program activities and expected use of CDC funds.
- Track progress on state program activities and identify promising practices.
- Assist CDC in identifying the need for training and technical assistance.
- Standardize the state reporting process to facilitate evaluation.
- Enable CDC to answer requests for information more quickly and improve sharing of lessons learned among states.

## Funded Partnerships

**Directors of Health Promotion and Education (DHPE):** In 2008, DHDSPP continued to support the DHPE/CDC Internship Program for Students of Minority Serving Institutions.

**National Stroke Association:** DHDSPP assisted with funding for the Sixth Annual National Public Health Stroke Summit conducted by the National Stroke Association in Denver, Colorado, in December 2007. The Summit brought together 105 state public health and health care professionals to promote information sharing, knowledge and skill building, networking, and partnership development.

## National Collaborations

### **Cardiovascular Health (CVH) Council of the National Association of Chronic Disease**

**Directors (NACDD):** In 2008, the CVH Council updated its section of the NACDD website to include additional materials useful to states, and it started a Web discussion forum that allows states to share ideas and products. The Council obtained private funds and sponsored the 2-day Northeast Regional Workshop on Cholesterol Control, in which 11 states participated, in May 2008. It also funded two of the participating states (Maine and Maryland) to do follow-up work on cholesterol control with their primary care associations and local federally qualified health centers. In March 2008, the Council led the development of a themed issue of the e-journal *Preventing Chronic Disease*. In most cases, state program staff coauthored articles with DHDSPP staff. The CVH Council worked with DHDSPP to assess the training needs of state programs in the National Heart Disease and Stroke Prevention Program, and DHDSPP used this information to plan its September 2008 3-day training workshop for state program and WISEWOMAN staff.

## Epidemiology and Surveillance Branch

### **Cardiac Arrest Registry to Enhance Survival**

The Cardiac Arrest Registry to Enhance Survival (CARES) began in 2005 in Atlanta and has since expanded to 40 communities in 23 states. CARES is a simple but robust registry of cardiac arrest events that allows participating sites to enter data related to out-of-hospital cardiac arrest (OHCA), generate summary reports, and compare local data with similar EMS systems elsewhere. Three sources of data are linked to describe each OHCA event: 1) 9-1-1 call center data (to provide incident address

and dispatch and arrival times), 2) EMS data (to describe initially recorded cardiac rhythm and treatment methods), and 3) hospital data (emergency department and hospital outcome, hypothermia treatment, and neurologic status at discharge). Multiple reporting features can be generated and monitored continuously through secure online access by CARES participants, which allows for longitudinal, internal benchmarking. Local EMS administrators and medical directors are able to identify when and where cardiac arrests occur, which elements of their EMS system are functioning properly in dealing with these cases, and what changes can be made to improve outcomes. In 2011, CARES began expanding to statewide participation in six states, which will allow additional communities of different sizes and population densities to be included in the registry. In addition, state-level participation will promote better communication and collaboration between state and local EMS providers. A recent MMWR Surveillance Summary was published summarizing CARES data collected during October 1, 2005–December 31, 2010 ([www.cdc.gov/mmwr/pdf/ss/ss6008.pdf](http://www.cdc.gov/mmwr/pdf/ss/ss6008.pdf)). More information about CARES can be found on the CARES website at <https://mycares.net>.

## Paul Coverdell National Acute Stroke Registry

**New Registries:** The Paul Coverdell National Acute Stroke Registry program successfully implemented stroke registries in three newly funded states in 2007 (Michigan, Minnesota, and Ohio). These states made much greater progress in their first year toward developing program infrastructure, collecting data, and engaging in quality improvement activities than had the four states that completed their first year of Coverdell Registry funding in 2004. Much of this progress can be attributed to CDC's increased capacity to provide proactive technical assistance to states through conference calls, work groups, and resource materials, such as the program resource manual.

**Supplemental Projects:** The Coverdell Registry team developed and funded a supplemental cooperative agreement to pilot the expansion of the Coverdell Registry model to other domains within stroke systems of care. North Carolina was funded to demonstrate the feasibility of linking pre-hospital EMS data for stroke with the state Coverdell Registry (the North Carolina Stroke Care Collaborative). In 2010, in partnership with the Association of State and Territorial Health Officials, CDC funded two Coverdell states to develop comprehensive statewide stroke care systems plans. CDC is currently funding the Ohio Coverdell Registry to study 30-day outcomes of stroke patients based on the quality of care provided. In partnership with the Agency for Healthcare Research and Quality, CDC has funded an evidence-based review of transitions in care from hospital to home or rehabilitation for stroke patients.

**National Evaluation Plan:** Through a yearlong collaboration with RTI International, the Coverdell Registry developed a national evaluation plan. The plan provides a systematic method of assessing the annual and long-term performance of the program, including strategic goals and objectives, performance goals, performance measures, and targets for program outcomes.

## Consensus Stroke Performance Measures

### Endorsement of the Consensus Stroke

**Performance Measures:** The Coverdell Registry partnered with the American Heart Association and The Joint Commission to develop performance measures for acute stroke care, commonly referred to as the Consensus Stroke Performance Measures. These measures were released to hospitals throughout the United States in fall 2007. In January 2008, more than 1,200 hospitals began using these measures to improve the quality of care for acute stroke patients. The measures

were submitted to the National Quality Forum in March 2008, and 8 of the 10 were adopted. This endorsement of the Consensus Stroke Performance Measures has paved the way for adoption of these measures by the Centers for Medicare and Medicaid Services for quality reporting and meaningful use.

**Quarterly Data Reports:** With the implementation of the Consensus Stroke Performance Measures in January 2008, CDC began providing states with quarterly data reports on the measures. These reports provide each state with a summary of its data on ischemic stroke, hemorrhagic stroke, and transient ischemic attacks as well as aggregate data for all states in the Coverdell Registry program.

## Applied Research and Evaluation Branch

### Building an Economic Evaluation Research Agenda

Based on program needs and research gaps in heart disease and stroke prevention, the Applied Research and Evaluation Branch developed an agenda to guide economic research on 1) economic burden of cardiovascular diseases and cost-effectiveness of their control, 2) economic value of DHDSP-funded and other state prevention programs, 3) CDC's Internet-based clearinghouse for information on the economics of cardiovascular diseases, and 4) developing partnerships in economic research to increase the impact of such research.

### Stroke Awareness: Signs and Symptoms Awareness Campaigns

To provide guidance for state programs, a review of current research on stroke awareness campaigns was undertaken to identify evidence to support the most appropriate ways to increase knowledge of signs and

symptoms for stroke, the importance of calling 9-1-1, and relationships between the educational campaigns and outcomes related to awareness of stroke signs and symptoms.

The literature review and synthesis of current research on stroke awareness campaigns resulted in the following dissemination activities:

- Development of a fact sheet for state programs on literature review findings and considerations for states' current activities related to stroke awareness messages, including direct education and tools available to facilitate campaign development.
- Poster presentation at the 2008 National Conference on Health Communication, Marketing and Media on evaluation guidance for stroke awareness campaigns. The presentation outlined specific information for states and communities on how to strengthen the effectiveness and outcome evaluation of their stroke awareness campaigns.
- Presentation at the 2008 National Heart Disease and Stroke Prevention Training Institute about evidence and research on communication and media campaigns, impact, considerations of cost, opportunities for partnering, and evaluating results.

### Comprehensive and Core Indicators

DHDSP released a set of core indicators for hypertension as part of a comprehensive, evidence-based set of indicators to guide state heart disease and stroke prevention programs in evaluating their efforts. State health departments received related key guidance documents, training at the National Heart Disease and Stroke Prevention Training Institute, and a series of follow-up trainings. Indicators are presented in a *Consumer Reports* format and rated on multiple dimensions, such as strength of scientific evidence, feasibility of data collection, and face validity.

## Successful Business Strategies to Prevent Heart Disease and Stroke Toolkit—Evaluation Results

CDC worked with the American Institutes for Research (AIR) to conduct an evaluation of the Successful Business Strategies to Prevent Heart Disease and Stroke Toolkit. State health departments (SHDs) were trained to use the toolkit to promote state employer-based initiatives on workplace efforts for heart disease and stroke prevention.

From 2005 to 2007, all the SHDs received copies of the toolkit and were invited to attend training sessions (one seminar, five webinars, and three consultations). To evaluate the usefulness of the toolkit materials and obtain recommendations, two focus groups with business leaders and Web-based surveys of the SHDs were conducted. In 2006, all 50 states and the District of Columbia completed the baseline, and in 2008, 40 states completed the follow-up.

Of the 40 SHDs that completed both waves of the survey, the proportion that reported engaging in employer-based initiatives significantly increased from 65 percent to 72.5 percent during the period examined, despite a reported reduction in staff and limited appropriations. About 90 percent of the SHDs that responded to the 2008 survey are now working with employers to promote comprehensive heart disease and stroke prevention programs,

disseminate best practices, establish employer-oriented partnerships, participate in seminars for employers, and provide business leaders with resources. Partnerships with employer groups or business coalitions have focused on worksite policy changes, health promotion and education, and worksite surveillance and assessments. In parallel to these experiences, the SHDs have increased their overall level of confidence in their knowledge and skills. Most of the SHDs (61 percent) agreed that the CDC trainings and consultations helped them improve their heart disease and stroke prevention programs and use the toolkit more effectively. Participation in the trainings was positively associated with engagement in worksite health promotion and education. The SHDs that received federal funding had significantly higher participation in macro-marketing activities, reaching employers through business coalitions, associations, task forces, and champions, and were more likely to establish partnerships with employer groups and government agencies.

The Successful Business Strategies to Prevent Heart Disease and Stroke Toolkit is available at [www.cdc.gov/dhdsp/library/toolkit/index.htm](http://www.cdc.gov/dhdsp/library/toolkit/index.htm).

The Branch also provides economics support to the Division and partners by documenting costs of cardiovascular diseases and their risk factors and identifying cost-effective interventions.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

# National Heart Disease and Stroke Prevention Program Overview

## Program Overview

- In 1998, the U.S. Congress provided funding for CDC to initiate a national, state-based Heart Disease and Stroke Prevention (HDSP) program in eight states.
  - CDC funds programs in 41 states and the District of Columbia. Twenty-eight are capacity building (planning) programs, and 14 are basic implementation (intervention) programs.
  - **Capacity Building Programs:** Alabama, Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Nebraska, New Jersey, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, and Wisconsin.
  - **Basic Implementation Programs:** Arkansas, Florida, Georgia, Maine, Massachusetts, Missouri, Montana, New York, North Carolina, South Carolina, Utah, Virginia, Washington, and West Virginia.
- ▶ **Blood pressure:** Prevent and control high blood pressure; reduce sodium intake.
  - ▶ **Cholesterol:** Prevent and control high cholesterol.
  - ▶ **Smoking:** Increase the number of smokers counseled to quit and referred to quitlines by health care workers; increase availability of no or low-cost cessation products; and collaborate with efforts to increase the percentage of the population protected by smoke-free air laws and regulations.

To a lesser extent, state HDSP programs work to improve emergency response and quality of acute care systems.

State HDSP programs work to eliminate health disparities in priority populations (i.e., groups with increased burden or need based on race, ethnicity, gender, geography, or socioeconomic status) as an overarching principle.

## National Heart Disease and Stroke Prevention Program Goals

- Enhance state capacity to plan, implement, track, and sustain population-based interventions to address heart disease, stroke, and related risk factors. Focus program efforts on population-based policy and systems change strategies to impact the “ABCS” of heart disease and stroke prevention:
  - ▶ **Aspirin:** Increase low-dose aspirin therapy according to recognized guidelines.
- Collaborate with chronic disease programs (e.g., those focusing on tobacco, diabetes, physical inactivity, poor nutrition, and obesity/overweight) and partners to develop and integrate population-based strategies to prevent heart disease and stroke.
- Promote cardiovascular health in health care, worksite, and community settings through policy and systems changes.
- Identify and evaluate promising practices to address heart disease and stroke.
- Conduct surveillance of heart disease, stroke, and related risk factors.

## Key Responsibilities of State Capacity Building Programs

- Facilitate collaboration with public- and private-sector partners, such as not-for-profit health agencies, health systems organizations, emergency response agencies, federally funded health centers, businesses, priority population organizations, and voluntary health organizations.
- Document the state burden of heart disease, stroke, and related risk factors.
- Develop plans for population-based strategies for preventing heart disease and stroke among general and Priority Populations.
- Develop a comprehensive state HDSP plan.
- Develop an HDSP program logic model and evaluation plan.
- Assess assets and gaps in state policy and systems related to HDSP in health care, worksite, and community settings.

## Key Responsibilities of State Basic Implementation Programs

- Enhance all capacity-building program activities.
- Implement and evaluate policy, systems change, and educational interventions that address the six HDSP program priority areas in health care, worksite, and community settings.
- Provide training and technical assistance to public health and health care professionals and partners to support policy and system changes that will encourage heart disease and stroke prevention.

## How CDC Assists State Heart Disease and Stroke Prevention Programs

- Provides training, technical assistance, and funding.
- Funds applied research on heart disease and stroke interventions and elimination of disparities that is relevant to state programs.
- Identifies and disseminates science-based promising practices.
- Partners with national organizations to help states address prevention of heart disease and stroke.
- Facilitates collaborations with other state chronic disease programs or activities that address risk factors, populations, or settings related to heart disease and stroke prevention and program priority areas.
- Develops and disseminates publications and tools, such as:
  - ▶ *CDCynergy*, a CD-ROM-based tool for planning health communication interventions.
  - ▶ *State Heart Disease and Stroke Prevention Program: Evaluation Framework* ([www.cdc.gov/dhdsp/library/evaluation\\_framework/index.htm](http://www.cdc.gov/dhdsp/library/evaluation_framework/index.htm)), a document providing guidance on systematic ways to measure the success of public health programs and on logic model development.
  - ▶ *State Heart Disease and Stroke Prevention Program: Evaluation Guide—Developing an Evaluation Plan* ([www.cdc.gov/DHDSP/state\\_program/evaluation\\_guides/evaluation\\_plan.htm](http://www.cdc.gov/DHDSP/state_program/evaluation_guides/evaluation_plan.htm)), a document providing guidance on the development of evaluation activities to help programs identify required staff time and resources.

- ▶ *State Heart Disease and Stroke Prevention Program: Evaluation Guide—Developing and Using a Logic Model* ([www.cdc.gov/DHDSP/state\\_program/evaluation\\_guides/logic\\_model.htm](http://www.cdc.gov/DHDSP/state_program/evaluation_guides/logic_model.htm)), a document providing guidance on the development and use of logic models as planning and evaluation tools.
- ▶ *State Heart Disease and Stroke Prevention Program: Evaluation Guide—Writing SMART Objectives* ([www.cdc.gov/DHDSP/state\\_program/evaluation\\_guides/smart\\_objectives.htm](http://www.cdc.gov/DHDSP/state_program/evaluation_guides/smart_objectives.htm)), a document providing guidance to states on the development of realistic and measurable objectives.
- ▶ *Successful Business Strategies to Prevent Heart Disease and Stroke Toolkit* ([www.cdc.gov/dhdsp/library/toolkit/index.htm](http://www.cdc.gov/dhdsp/library/toolkit/index.htm)), a document that provides information, materials, and tools that state programs can reference and distribute to businesses, primarily through employer and professional organizations.
- ▶ *Heart Disease and Stroke Interactive Maps* ([www.cdc.gov/dhdsp/library/maps/statemaps.htm](http://www.cdc.gov/dhdsp/library/maps/statemaps.htm)), which present heart disease and stroke mortality rates by county for the state, racial/ethnic group, and gender of the user's choice.
- ▶ *A Communication Guide for Policy and Environmental Change* ([www.cdc.gov/dhdsp/library/heart\\_stroke\\_guide/index.htm](http://www.cdc.gov/dhdsp/library/heart_stroke_guide/index.htm)), which includes information, references, and examples of communication from state programs, and *Stroke Addendum to the Communication Guide* ([www.cdc.gov/dhdsp/library/heart\\_stroke\\_guide/index.htm](http://www.cdc.gov/dhdsp/library/heart_stroke_guide/index.htm)).

For additional information, please visit the CDC website at [www.cdc.gov/dhdsp](http://www.cdc.gov/dhdsp) or contact the Division for Heart Disease and Stroke Prevention, Program Development and Services Branch, at (770) 488-2424.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

State Heart Disease and  
Stroke Prevention Program  
Funding Opportunity  
Announcement DP07-704  
At-A-Glance

## Introduction

The Funding Opportunity Announcement (FOA) DP07-704 At-A-Glance provides important information to assist programs funded under this announcement to deliver their program as intended. The At-A-Glance highlights aspects of FOA DP07-704 important for all funded programs, including the following:

- Overview of the National Heart Disease and Stroke Prevention Program.
- Heart Disease and Stroke Prevention State Program roles.
- Performance measures for Capacity Building, Basic Implementation, Optional Funding for Capacity Building programs, and Stroke Networks.
- Funded program reporting requirements.
- Budget/funding guidance.
- National and administrative policy requirements.

If a program needs a copy of the full document, it should contact its project officer (see Program Contacts section of the full National Heart Disease and Stroke Prevention Program Staff Orientation Manual) to fulfill that request.

## Section 1: Background

In 1998, the U.S. Congress provided funding for CDC to initiate a national, state-based cardiovascular health program. The Senate Appropriations Committee in 2005 encouraged CDC to create the Division for Heart Disease and Stroke Prevention and increased resources, enabling CDC to reach 32 of the 50 states and the District of Columbia with funding for heart disease and stroke prevention. As of 2008, the Heart Disease and Stroke Prevention (HDSP) program funds 41 states and the District of Columbia.

As the Division for Heart Disease and Stroke Prevention developed, so did the focus of the State HDSP Program. Focusing on the six program priority areas (noted below) should impact morbidity and mortality of these diseases. State programs should increase heart disease and stroke prevention policies and systems change with the potential to impact the general population and Priority Populations (see *Prevention Works: CDC Strategies for a Heart-healthy and Stroke-free America*, [www.CDC.gov/dhdsp/library](http://www.CDC.gov/dhdsp/library)). For more information on the CDC State HDSP Program, visit [www.cdc.gov/dhdsp/State\\_program/index.htm](http://www.cdc.gov/dhdsp/State_program/index.htm).

*A Public Health Action Plan to Prevent Heart Disease and Stroke* (see [www.CDC.gov/dhdsp/library](http://www.CDC.gov/dhdsp/library)) documents the multiple intervention opportunities for preventing heart disease and stroke. It is important to work with partners collaboratively in leveraging resources to address the multiple risk factors that are associated with these diseases.

Announcement DP07-704 supports program components considered essential to enhancing the leadership of state health departments in heart disease and stroke prevention. It provides for the funding of capacity building and basic implementation programs as well as projects such as the Optional Funding for Capacity Building Programs and Stroke Networks.

A capacity building program develops the foundation for a comprehensive cardiovascular disease prevention program through such activities as partnership development, definition of the burden, and development of a state plan. A basic implementation program enhances capacity building activities and implements, disseminates, and evaluates intervention activities that address the state plan objectives and the CDC program priority areas 1–6:

1. Increase control of high blood pressure, primarily in adults and older adults.

2. Increase control of high blood cholesterol, primarily in adults and older adults.
3. Increase knowledge of signs and symptoms for heart attack and stroke and the importance of calling 9-1-1.
4. Improve emergency response.
5. Improve quality of heart disease and stroke care.
6. Eliminate disparities in terms of race, ethnicity, gender, geography, or socioeconomic status.

Optional Funding for Capacity Building Programs provides support to programs to implement an evidence-based or promising practice demonstration project that addresses the CDC program priority areas 1–6.

Stroke Networks support a state health department to increase stroke prevention activities across a group of three to six contiguous member states with emphasis on increasing awareness and implementing priority policy or systems changes across the states.

The State HDSP Program is anchored on the framework of the Socio-ecological Model, which conceptualized the influences of individual behaviors, family and social relationships, community and environmental effects, and societal influences such as policies on health status. In order to promote significant impact for improving the health of the population, interventions should focus on implementing policy and systems change strategies that support heart disease and stroke prevention.

Policy change can be addressed through a) public policy (e.g., establishing certification for hospital-based stroke centers) or b) organizational policy (e.g., businesses providing health benefits plans that cover preventive services that include blood pressure control).

System changes are encouraged in three settings: worksites, health care, and communities. An example of a systems change is when a health care setting implements electronic records and patient care management systems that improve the quality of health care. Interventions within systems are encouraged at the highest level possible—for example, activities with business coalitions rather than individual worksites and with managed care organizations (MCOs) and state medical associations rather than individual health care sites or physicians. By working at higher levels to affect systems change, states can impact larger segments of the population.

Education and awareness efforts to enhance public understanding and promote actions related to cardiovascular diseases and the risk factors of high blood pressure and high cholesterol, signs and symptoms of heart attack and stroke, and the need to call 9-1-1 are also components of capacity enhancement.

An overarching goal of the State HDSP Program is to address disparities in heart disease and stroke and the related risk factors using policy and systems change strategies. Based on disparities (e.g., race/ethnicity, gender, geographic, geography, socioeconomic status) in mortality, access to care, or burden of risk factors, the State HDSP Program should identify Priority Populations and implement interventions to reach those Priority Populations.

No one organization will be able to address the prevention of heart disease and stroke. It will require many organizations working in collaboration if progress is to be made in accomplishing the Healthy People 2010 Objectives. Collaboration is defined by the Wilder Foundation as “a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to mutual relationships and goals; a jointly developed structure

and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards.” Developing and maintaining strategic partnerships are key to the leveraging of skills and resources to prevent heart disease and stroke in a comprehensive way. The State HDSP Program has two major roles related to partners. The first is to convene or facilitate collaboration to develop and implement a comprehensive state plan and intervention implementation strategies that addresses heart disease, stroke, and related risk factors. The second is to develop strategies to leverage resources and coordinate interventions with partners that address the six program priority areas.

A logic model has been developed to describe the State HDSP Program as intended by the CDC funding to state health departments (see following page). The model depicts relationships and actions (e.g., links between environment and policy change and individual-level behavioral change) that are expected to culminate in reduction in heart disease and stroke.

The CDC and state activities are outlined in terms of capacity building, surveillance/monitoring, and interventions. Both CDC and state activities influence changes that lead to short-term outcomes, such as development of a work plan and strategies for system-level changes, effective implementation of interventions, and action by target audiences and change agents (those who are in the position to influence policies and systems such as hospital administrators and MCO decision makers). These activities and outcomes result in changes in policy and environmental supports, which in turn influence behavior changes and improve health status. Ultimately, these changes decrease premature death and disability and eliminate cardiovascular disparities between general and Priority Populations.

The State HDSP logic model also is a tool to guide program evaluation. By identifying the steps necessary to reach intended outcomes, the logic model provides guidance in evaluating the short and intermediate outcomes of the program.

State evaluation efforts should relate to the National HDSP Program logic model or to a logic model that the state develops that complements the national model and the required program recipient activities. The logic model can also be seen in the CDC Evaluation Framework for Heart Disease and Stroke Prevention State Programs at [www.cdc.gov/dhdsp](http://www.cdc.gov/dhdsp).

## Section 2: National Heart Disease and Stroke Prevention State Program Roles

In *A Public Health Action Plan to Prevent Heart Disease and Stroke*, there are four major goals, which are based on Healthy People 2010:

- Goal 1: Prevention of risk factors.
- Goal 2: Detection and treatment of risk factors.
- Goal 3: Early identification and treatment of heart attacks and strokes.
- Goal 4: Prevention of recurrent cardiovascular events.

CDC-funded State HDSP Programs have a direct impact on Goals 2, 3, and 4 by addressing HDSP program priority areas 1–6 (see Background section). HDSP programs have a supportive role with other state health department programs and partners in addressing Goal 1. Efforts to address Goal 1 related to tobacco use, diabetes, obesity, poor nutrition, physical inactivity, and schools as a worksite should be done through a supportive or collaborative role with the state WISEWOMAN, diabetes, tobacco, nutrition, physical activity, or coordinated school health programs.

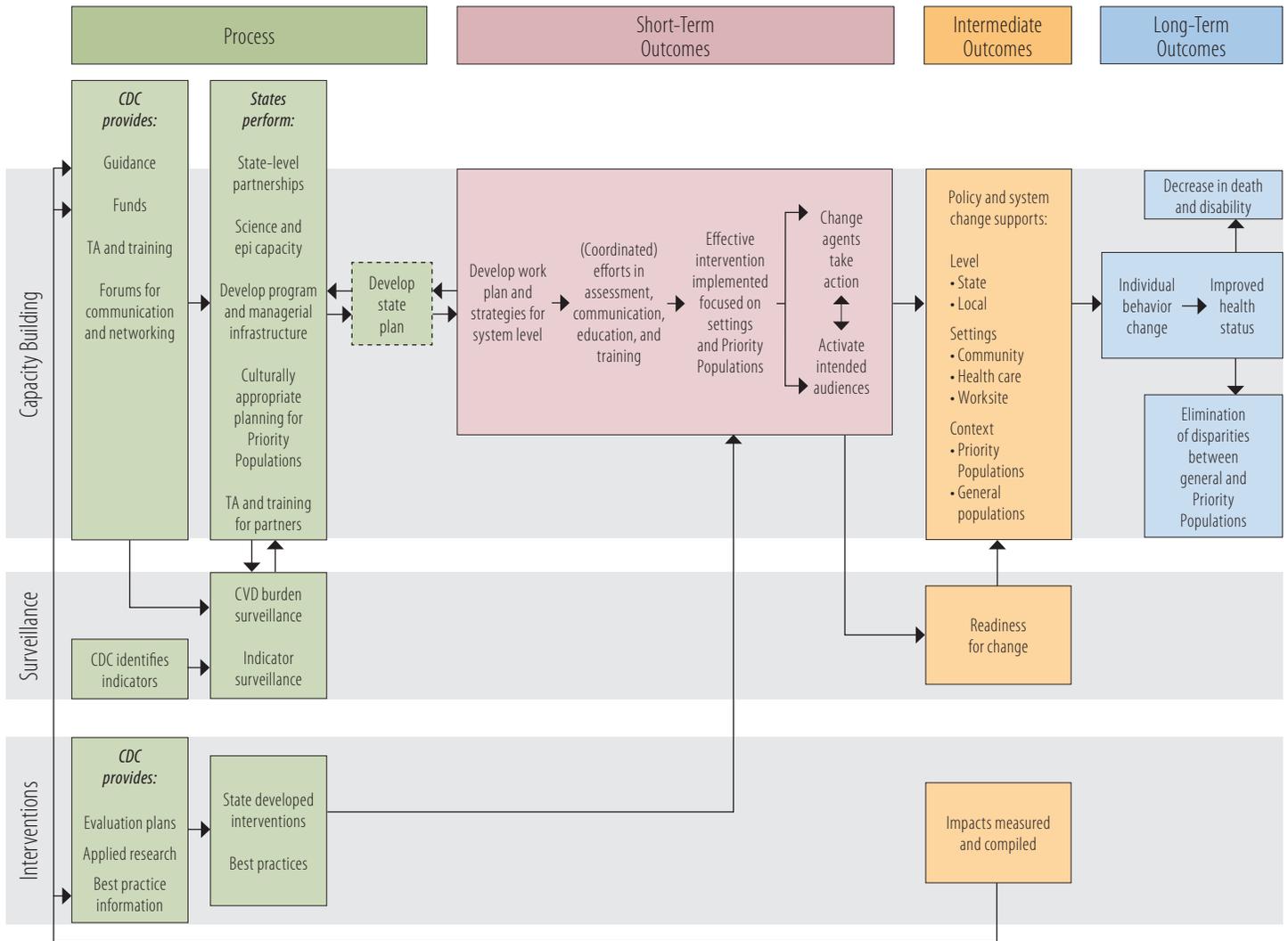
- State HDSP Programs are encouraged to coordinate with other programs in ways that:

1. Address Goal 1 (e.g., State HDSP and Nutrition Programs identify primary prevention messages related to cholesterol and salt to be included in Nutrition Programs where appropriate; State HDSP and Tobacco Programs collaborate to promote use of state tobacco quit lines; State HDSP Program refers managed care organizations to materials developed by the Parks and Recreation Department and Physical Activity Program on safe places to exercise;

State HDSP and WISEWOMAN Programs collaborate to create systems for educating health care providers on guidelines focused on risk factor prevention).

2. Enhance inclusion of key messages in the work of related programs (e.g., State HDSP Program works to implement JNC7 guidelines, which include referral to nutrition counseling; the WISEWOMAN Program incorporates education on signs and symptoms of heart disease and stroke into ongoing activities; the State HDSP Program

### National HDSP Program Logic Model



encourages implementation of patient record systems that include family history).

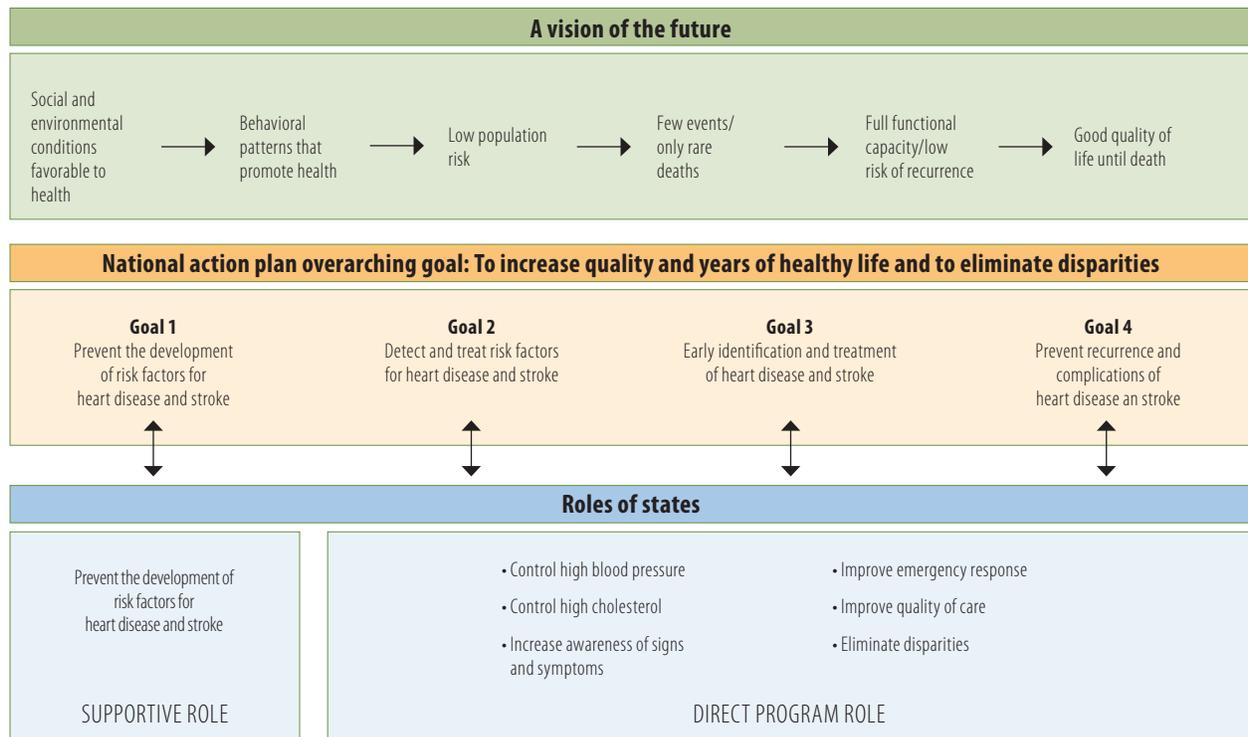
3. Coordinate work with partners (e.g., multiple health department programs that work with American Heart Association coordinate efforts with this partner where possible).
4. Coordinate work within settings (e.g., programs with related interests in healthy workplaces coordinate efforts to engage worksites or business coalitions; State HDSP and other chronic disease programs work collaboratively with community health centers to implement systems change to increase blood pressure control).
5. Maximize the public health benefit from the use of CDC funding within approved budget line items to enhance the state's ability to achieve stated goals and objectives and respond to

changes in the field. (See Funding Section IV.5 for flexibility language related to use of funds.)

Flexibility language includes using staff time and funds for:

- a) Sharing positions (e.g., the State HDSP and Nutrition Program sharing the costs of a policy analyst).
- b) Conducting training activities (e.g., program funding staff and partners on common skills such as program evaluation, ways to reduce disparities, use of data for program planning or use of policy and systems change strategies).
- c) Planning (e.g., joint planning on how to address disparities; programs jointly plan a state public health conference that addresses common skills and specific program-related sessions).

### Action Framework for a Comprehensive Public Health Strategy to Prevent Heart Disease and Stroke



- d) Developing procedures and formats that increase understanding across programs (e.g., consistent formats for documents such as state plans and descriptions of burden).
- State health departments should determine how best to facilitate coordination and cooperation among existing categorical program efforts while allowing each program to maintain individual integrity and identity.
- States should utilize tools, including the Partners for Prevention document Comprehensive and Integrated Chronic Disease Prevention: Action Planning Handbook for States and Communities (at [www.prevent.org](http://www.prevent.org)), which contains activities to help state programs identify areas of collaboration for mutual benefit, increase efficiency, and better serve the people of the state.

## Section 3: Performance Measures by Funding Designation

### Capacity Building Performance Measures

At the time of application, states applying for funding may have already achieved various performance measures for capacity building. States should review the following measures, identify those already achieved, and plan to address the remaining performance measures within the first 1 to 2 years of funding.

Annually:

- Collaborate with state health department partners on the planning and implementation of at least one capacity-building activity or state heart disease and stroke prevention plan activity.
  - Leverage resources from external partners to facilitate the development or implementation of the state heart disease and stroke prevention plan. Provide two narrative examples.
- By the end of year 1:
- Employ one full-time project manager.
  - Employ one half-time chronic disease epidemiologist.
  - Develop a heart disease and stroke burden profile for program planning and training.
  - Establish a state partnership comprising diverse partners.
  - Develop a plan for convening and maintaining a state partnership.
  - Convene one partnership meeting toward the development of a state plan.
- By the end of year 2:
- Complete a training needs assessment. Develop and implement a training plan to increase the capacity of staff and partners.
  - Publish in hard copy a state heart disease and stroke burden report.
- By the end of year 3:
- Publish in hard copy a comprehensive state plan that uses burden and assessment findings; addresses prevention of heart disease and stroke; addresses heart disease and stroke risk factors; proposes policy and systems changes as approaches to the six priority areas; identifies how progress toward successful achievement of the plan will be evaluated; and documents partner involvement in planning and implementing the state plan.

- Complete an evaluation of the state partnership, including, for example, partner satisfaction, commitment and involvement, infrastructure and functioning, effectiveness and outcomes, and sustainability.
- Develop an approach to implementing the state plan as part of the program work plan.

By the end of year 4:

- Implement the state plan in collaboration with partners using policy and systems change to address the six State HDSP Program priority areas.
- Develop an implementation plan for at least two population-based, policy or systems change interventions in one or more of the State HDSP Program priority areas, in collaboration with partners.

By the end of 5 years:

- Implement and initiate evaluation of a small-scale version of at least one of the population-based interventions proposed in year 4.
- Update the burden profile.
- Meet all criteria for requesting basic implementation funds and apply for basic implementation funding.

## Basic Implementation Program Performance Measures

Annually:

- Demonstrate progress toward achieving goals of the comprehensive state plan in collaboration with partners.
- Assure the state burden document has been published within the previous 5 years.

- Collaborate with state health department partners on the implementation of at least one state heart disease and stroke prevention plan activity.
- Collaborate with state health department partners on the implementation of at least one activity related to priority areas 1–6.
- Leverage resources from external partners to implement at least one state heart disease and stroke prevention plan activity. Provide a narrative example.
- Leverage resources from external partners to implement at least one intervention activity related to priority areas 1–6. Provide a narrative example.

By the end of year 1:

- Maintain one full-time project manager.
- Maintain one half-time chronic disease epidemiologist.
- Provide for one half-time evaluator or equivalent.
- Complete a training needs assessment of staff and partners. Develop and implement a training plan based on needs assessment.
- Update as needed a state heart disease and stroke burden profile for program planning.

By the end of year 2:

- Implement and initiate evaluation of at least two population-based policy/system change interventions to control high blood pressure and/or high blood cholesterol in the health care or worksite setting. This should include consideration of Priority Populations.
- Evaluate the state partnership. Include an evaluation of the effectiveness of the partnership in leveraging resources and implementing interventions.

By the end of year 3:

- Implement and initiate evaluation of at least one additional population-based policy/systems change intervention strategy in one of the remaining program priority areas (quality of care [other than high blood pressure or high cholesterol], emergency response, signs and symptoms in the health care or worksite setting). This should include consideration of Priority Populations.
- Update state heart disease and stroke burden profile.
- Document contributions of partners (leveraged resources) to implementing priority area policy and system change interventions.

By the end of year 4:

- Document continued progress on implementing and evaluating population-based interventions using the MIS.
- As applicable, evaluate interventions among Priority Populations.
- Use evaluation findings for program improvement. Submit a brief summary of intervention evaluation findings that includes an improvement plan.

By the end of the year 5:

- Expand existing or implement new population-based policy/systems change interventions in the program priority areas. As applicable, evaluate interventions among Priority Populations.
- Update state heart disease and stroke burden profile.
- Complete an executive summary of program accomplishments that covers the funding cycle, including policy and systems changes, impact of

policy and systems changes, and contributions of the partners (leveraged resources) to implementing priority area policy and systems change interventions.

### Capacity Building Performance Measures for Optional Funding

Includes evidence that the applicant has built significant capacity as specified in the Capacity Building Program Activities 1–4.

1. Evidence of a management plan that describes
  - a) program staffing and qualifications in terms of requirements in the program announcement; and
  - b) methods of communication between state health department programs that relate to heart disease and stroke prevention, including program priority areas 1–6.
2. Evidence of at least 10 diverse and active partners that include partners from state health department programs, other state agencies, organizations that promote cardiovascular health or address heart disease and stroke or related risk factors, organizations that improve health, and organizations that provide access to populations (including Priority Populations) or settings (including health care and worksites) by provision of documentation such as memoranda of understanding or other letters of agreements, summaries of meetings that delineate partners' leadership for completing tasks, outcomes or products of the partnership, and other documents that demonstrate collaboration on HDSP program activities with partners.
3. Evidence that a heart disease and stroke burden document has been published by provision of a burden document (published in the past 3 years) that describes the burden of heart disease and stroke and related risk factors; geographic and

demographic distribution of heart disease and stroke, including racial and ethnic disparities; and trends in heart disease and stroke.

4. Evidence of a draft heart disease and stroke prevention state plan developed with the input of partners from within and external to the state health department; evidence of a process for finalizing, publishing and implementing the plan.

### Stroke Network Performance Measures

By the end of Project Year 1:

- Hire a project coordinator.
- Convene a stroke network structure that may be composed of an advisory group with supporting work groups and committees.
- Demonstrate evidence of diverse partnerships with key stakeholders across member states and the region.
- Develop a document/publication describing regional stroke burden, risk factors, and geographic and demographic distribution of stroke.
- Develop a strategic plan with timelines that describes policy and systems change strategies that will be implemented in years 2 and 3.

By the end of Project Year 2:

- Utilize the strategic plan, timeline, burden data, and other assessment data (e.g., of policies, systems of care) to develop a stroke regional plan that defines goals, objectives, priorities, and policy and systems approaches and describes participation and commitment by partners across the region and within member states.
- Prioritize and select policy- and systems-level activities that will be implemented in a coordinated and uniform fashion across the region.

- Develop an evaluation strategy that will be used to assess the selected activities.

By the end of Project Year 3:

- Provide evidence of the implementation of uniform policy and systems change activities across the region.
- Demonstrate the effectiveness of stroke network structure and partnerships.
- Utilize network data to engage stakeholders in promoting policy and systems change activities. Promote stroke network accomplishments through such means as reports, journal articles, presentations, best practices, a website, etc.
- Evaluate stroke network impact on the regional stroke burden, statewide or organizational policies, or policy and decision makers.
- Enhance stroke network partnership and leverage resources to ensure sustainability of activities.

## Section 4: Reporting Requirements

The applicant must provide CDC with the following reports:

1. Interim progress report, due March 12. The progress report will serve as the non-competing continuation application and must contain the following elements:
  - a) Current Budget Period Activities/Objectives Progress.
  - b) Current Budget Period Financial Progress.
  - c) New Budget Period Program Proposed Activities and Objectives.
  - d) Budget.

- e) Measures of Effectiveness.
- f) Additional Requested Information.

**The Interim Progress Report should be submitted using the HDSP MIS.**

2. Financial status report and annual progress report due no more than 90 days after the end of the budget period.
3. Annual progress report should be submitted using the CDC Heart Disease and Stroke Prevention MIS. It should report on activities for the year of funding.
4. Final performance and Financial Status reports due no more than 90 days after the end of the project period.

The reports must be mailed to the Grants Management Specialist listed in the program’s Notice of Award.

## Section 5: Budget Guidance and Funding Restrictions

Restrictions, which must be taken into account while writing the budget, are as follows:

- Funds may not be used for research.
- Reimbursement of pre-award costs is not allowed.
- Funds may not be used to supplant state or local funds.
- Funds may not be used for construction.
- Funds may not be used to provide health screening, patient care, personal health services, medications, patient rehabilitation, or other costs associated with the treatment of heart disease or stroke.

- Awardees may not generally use HHS/CDC/ATSDR funding for the purchase of furniture or equipment. Any such proposed spending must be identified in the budget.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.

Guidance for completing the budget can be found on the CDC website at [www.cdc.gov/od/pgo/funding/budgetguide.htm](http://www.cdc.gov/od/pgo/funding/budgetguide.htm).

As part of the increased flexibility efforts, applicants are encouraged to maximize the public health benefit from the use of CDC funding within the approved budget line items and to enhance the grantee’s ability to achieve stated goals and objectives and to respond to changes in the field as they occur, within the scope of the award. Recipients also can redirect up to 25 percent of the total approved budget or \$250,000, whichever is less, to achieve stated goals and objectives within the scope of the award, except from categories that require prior approval, such as contracts, change in scope, and change in key personnel. A list of required prior approval actions is included in the Notice of Grant Award.

## Section 6: Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 and Part 92, as appropriate. The following additional requirements apply to this project:

- AR-8 Public Health System Reporting Requirements
- AR-9 Paperwork Reduction Act Requirements

- AR-10 Smoke-Free Workplace Requirements
- AR-11 Healthy People 2010
- AR-12 Lobbying Restrictions
- AR-14 Accounting System Requirements
- AR-23 States and Faith-Based Organizations
- AR-24 Health Insurance Portability and Accountability Act Requirements

- AR-25 Release and Sharing of Data
- AR-27 Conference Disclaimer and Use of Logos

Additional information on the requirements can be found on the CDC website at [www.cdc.gov/od/pgo/funding/Addtl\\_Reqmnts.htm](http://www.cdc.gov/od/pgo/funding/Addtl_Reqmnts.htm).

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at [www.gpoaccess.gov/cfr/index.html](http://www.gpoaccess.gov/cfr/index.html).

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

# Management Information System (MIS) At-A-Glance

## About the Heart Disease and Stroke Prevention Management Information System (HDSP MIS)

The HDSP MIS is a reporting system that allows each funded Heart Disease and Stroke Prevention Program to document information relevant to its program, such as the state's work plan and evaluation measures; track the progress of its program; and create and submit required progress reports to CDC.

The HDSP MIS supports funded state Heart Disease and Stroke Prevention Programs in the following ways:

- Enables states to describe their program activities and expected use of CDC funds for heart disease and stroke prevention.
- Enables CDC to track progress on state program activities and identify promising practices.
- Reduces both the states' and CDC's burden of program planning, reporting, and overall administration.
- Assists CDC in identifying the need for training and technical assistance.
- Standardizes the state reporting process to facilitate evaluation.
- Enables CDC to answer requests for information more quickly and improve sharing of lessons learned among states.

## Access to HDSP MIS

To access the HDSP MIS, follow the steps below:

1. Open your Internet Web browser (i.e., Internet Explorer, Netscape) by clicking on the desktop icon or by clicking the Start button, selecting

“Programs,” and clicking the button for your browser.

2. In the Web browser, type in the Web address <http://apps.nccd.cdc.gov/hdspmis> and press the Enter key. The HDSP login screen is displayed.

**Recommendation:** If you have not already done so, you might want to bookmark the HDSP MIS website (or make it a favorite) on your Web browser so you won't have to type in the URL the next time you want to access it.

3. On the login screen, enter your assigned user ID and password and click “login.” If you enter your user ID or password incorrectly three times, you will be locked out of the system for approximately 1 hour.

The HDSP MIS home screen is displayed.

**For new HDSP-funded staff members:** To request access to MIS (HDSP-funded staff only), please e-mail Shanda Blue at [sblue@cdc.gov](mailto:sblue@cdc.gov). The e-mail request should include the program staff person's full name, phone number, and e-mail address.

## MIS Help Manual Access Information

A help manual is available to assist HDSP-funded programs with navigating the HDSP MIS. To access the help manual, first log on to the MIS. Then complete the following steps:

1. Click on the word “help” in the right-hand corner.
2. Click “show navigation pane.”
3. Once the navigation pane is shown, click on “training manual” to access the manual.
4. The manual is a PDF document that can be printed in its entirety or by chapter.

## MIS/Programmatic Information Contacts

For support regarding use of the HDSP MIS, guidance on the type of information that should be documented in the HDSP MIS, or technical issues, HDSP staff should contact the Project Officer assigned to their program.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

# Guidelines for Budget Preparation

## Introduction

Guidance is offered for the preparation of a budget request. Following this guidance will facilitate the review and approval of a requested budget by insuring that the required or needed information is provided.

### A. Salaries and Wages

For each requested position, provide the following information: name of staff member occupying the position, if available; annual salary; percentage of time budgeted for this program; total months of salary budgeted; and total salary requested. Also, provide a justification and describe the scope of responsibility for each position, relating it to the accomplishment of program objectives.

#### Sample Budget

<b>Personnel</b>					<b>Total \$ _____</b>
<i>Position Title and Name</i>	<i>Annual</i>	<i>Time</i>	<i>Months</i>	<i>Amount Requested</i>	
Project Coordinator Susan Taylor	\$45,000	100%	12 months	\$45,000	
Finance Administrator John Johnson	\$28,500	50%	12 months	\$14,250	
Outreach Supervisor (Vacant*)	\$27,000	100%	12 months	\$27,000	

#### Sample Justification

The format may vary, but the description of responsibilities should be directly related to specific program objectives.

Job Description: Project Coordinator—(Name)

This position directs the overall operation of the project; is responsible for overseeing the implementation of project activities, coordination with other agencies, development of materials, provisions of in service and training, and conducting meetings; designs and directs the gathering, tabulating, and interpreting of required data; is responsible for overall program evaluation and for staff performance evaluation; and is the responsible authority for ensuring necessary reports/documentation are submitted to CDC. This position relates to all program objectives.

## B. Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed.

### Sample Budget

**Fringe Benefits** **Total \$** \_\_\_\_\_

25% of Total Salaries = Fringe Benefits

If fringe benefits are not computed by using a percentage of salaries, itemize how the amount is determined.

Example: Project Coordinator – Salary      \$45,000

Retirement 5% of \$45,000      =      \$2,250

FICA 7.65% of \$45,000      =      \$3,443

Insurance      =      \$2,000

Workers' Compensation      =      \_\_\_\_\_

Total:

## C. Consultant Costs

This category is appropriate when hiring an individual to give professional advice or services (e.g., training, expert consultant, etc.) for a fee but not as an employee of the grantee organization. Written approval must be obtained from CDC prior to establishing a written agreement for consultant services. Approval to initiate program activities through the services of a consultant requires submission of the following information to CDC (**see Other Information**):

1. Name of consultant;
2. Organizational affiliation (if applicable);
3. Nature of services to be rendered;
4. Relevance of service to the project;
5. Number of days of consultation (basis for fee); and
6. Expected rate of compensation (travel, per diem, other related expenses)—list a subtotal for each consultant in this category.

If the above information is unknown for any consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. In the body of the budget request, a summary should be provided of the proposed consultants and amounts for each.

## D. Equipment

Provide justification for the use of each item and relate it to specific program objectives. Maintenance or rental fees for equipment should be shown in the **Other** category.

### Sample Budget

<b>Equipment</b>			<b>Total \$</b> _____
<i>Item Requested</i>	<i>How Many</i>	<i>Unit Cost</i>	<i>Amount</i>
Computer Workstation	2 ea.	\$ 5,500	\$ 11,000
Computer	1 ea.	\$ 6,000	\$ 6,000
		<b>Total</b>	<b>\$ 17,000</b>

### Sample Justification

Provide complete justification for all requested equipment, including a description of how it will be used in the program.

**Note: Equipment**—Tangible non-expendable personal property (including exempt property) charged directly to an award having a useful life of more than 1 year AND an acquisition cost of \$5,000 or more per unit. However, consistent with recipient policy, a lower threshold may be established. Please provide the information to the Grants Management Officer to establish a lower equipment threshold to reflect your organization’s policy.

## E. Supplies

Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. If appropriate, General Office Supplies may be shown by an estimated amount per month times the number of months in the **Budget** category.

### Sample Budget

<b>Supplies</b>	<b>Total \$</b> _____
Computer workstation (specify type) 3 ea. x \$2500	= \$ 7,500
Computer (specify type) 2 ea. x \$3,300	= \$ 6,600
General office supplies (pens, pencils, paper, etc.) 12 months x \$240/year x 10 staff	= \$ 2,400
Educational pamphlets (3,000 copies @ \$1 each)	= \$ 3,000
Educational videos (10 copies @ \$150 each)	= \$ 1,500
Word processing software (@ \$400—specify type)	= \$ 400

### Sample Justification

Provide complete justification for all requested supplies, including a description of how it will be used in the program.

General office supplies will be used by staff members to carry out daily activities of the program. The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. Word processing software will be used to document program activities, process progress reports, etc.

### F. Travel

Dollars requested in the **Travel** category should be for **staff travel only**. Travel for consultants should be shown in the **Consultant** category. Travel for other participants, advisory committees, review panel, etc. should be itemized in the same way specified below and placed in the **Other** category.

**In-State Travel**—Provide a narrative justification describing the travel staff members will perform. List where travel will be undertaken, number of trips planned, who will be making the trip, and approximate dates. If mileage is to be paid, provide the number of miles and the cost per mile. If travel is by air, provide the estimated cost of airfare. If per diem/lodging is to be paid, indicate the number of days and amount of daily per diem as well as the number of nights and estimated cost of lodging. Include the cost of ground transportation when applicable.

**Out-of-State Travel**—Provide a narrative justification describing the same information requested above. Include CDC meetings, conferences, and workshops, if required by CDC. Itemize out-of-state travel in the format described above.

### Sample Budget

<b>Travel (in-state and out-of-state)</b>	<b>Total \$</b> _____
<i>In-State Travel:</i>	
1 trip x 2 people x 500 miles r/t x \$.27/mile	= \$ 270
2 days per diem x \$37/day x 2 people	= \$ 148
1 night's lodging x \$67/night x 2 people	= \$ 134
25 trips x 1 person x 300 miles avg. x \$.27/mile	= \$ 2,025
	_____
Total:	\$ 2,577

### Sample Justification

The Project Coordinator and the Outreach Supervisor will travel to (location) to attend AIDS conference. The Project Coordinator will make an estimated 25 trips to local outreach sites to monitor program implementation.

## Sample Budget

### *Out-of-State Travel:*

1 trip x 1 person x \$500 r/t airfare	=	\$ 500
3 days per diem x \$45/day x 1 person	=	\$ 135
1 night's lodging x \$88/night x 1 person	=	\$ 88
Ground transportation 1 person	=	\$ 50
		\$ 773
<b>Total:</b>		<b>\$ 773</b>

## Sample Justification

The Project Coordinator will travel to CDC, in Atlanta, GA, to attend the CDC Conference.

## G. Other

This category contains items not included in the previous budget categories. Individually list each item requested and provide appropriate justification related to the program objectives.

## Sample Budget

<b>Other</b>	<b>Total \$ _____</b>
Telephone (\$____ per month x ____ months x #staff)	= \$ Subtotal
Postage (\$____ per month x ____ months x #staff)	= \$ Subtotal
Printing (\$____ per x ____ documents)	= \$ Subtotal
Equipment Rental (describe) (\$____ per month x ____ months)	= \$ Subtotal
Internet Provider Service (\$____ per month x ____ months)	= \$ Subtotal

## Sample Justification

Some items are self-explanatory (telephone, postage, rent) unless the unit rate or total amount requested is excessive. If not, include additional justification. For printing costs, identify the types and number of copies of documents to be printed (e.g., procedure manuals, annual reports, materials for media campaign).

## H. Contractual Costs

Cooperative Agreement recipients must obtain written approval from CDC prior to establishing a third-party contract to perform program activities. Approval to initiate program activities through the services of a contractor requires submission of the following information to CDC (**see Other Information**):

1. Name of contractor;
2. Method of selection;
3. Period of performance;
4. Scope of work;
5. Method of accountability; and
6. Itemized budget and justification.

If the above information is unknown for any contractor at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. Copies of the actual contracts should not be sent to CDC, unless specifically requested. In the body of the budget request, a summary should be provided of the proposed contracts and amounts for each.

**I. Total Direct Costs** \$ \_\_\_\_\_

Show total direct costs by listing totals of each category.

**J. Indirect Costs** \$ \_\_\_\_\_

To claim indirect costs, the applicant organization must have a current approved indirect cost rate agreement established with the cognizant federal agency. A copy of the most recent indirect cost rate agreement must be provided with the application.

**Sample Budget**

**The rate is \_\_\_% and is computed on the following direct cost base of \$ \_\_\_\_\_.**

Personnel	\$ _____	
Fringe	\$ _____	
Travel	\$ _____	
Supplies	\$ _____	
Other	\$ _____	
<b>Total</b>	<b>\$ _____</b>	<b>x ___% = Total Indirect Cost</b>

If the applicant organization does not have an approved indirect cost rate agreement, costs normally identified as indirect costs (overhead costs) can be budgeted and identified as direct costs.

## Other Information

### Required Information for Consultant Approval

This category is appropriate when hiring an individual who gives professional advice or provides services for a fee and who is not an employee of the grantee organization. All consultants require prior approval from CDC annually. Submit the following required information for consultants:

1. Name of Consultant: Identify the name of the consultant and describe his or her qualifications.
2. Organizational Affiliation: Identify the organization affiliation of the consultant, if applicable.
3. Nature of Services To Be Rendered: Describe in outcome terms the consultation to be provided including the specific tasks to be completed and specific deliverables. A copy of the actual consultant agreement should not be sent to CDC.
4. Relevance of Service to the Project: Describe how the consultant services relate to the accomplishment of specific program objectives.
5. Number of Days of Consultation: Specify the total number of days of consultation.
6. Expected Rate of Compensation: Specify the rate of compensation for the consultant (e.g., rate per hour, rate per day). Include a budget showing other costs such as travel, per diem, and supplies.
7. Method of Accountability: Describe how the progress and performance of the consultant will be monitored. Identify who is responsible for supervising the consultant agreement.

## Required Information for Contract Approval

All contracts require prior approval from CDC. Funds may not be used until the following required information for each contract is submitted to and approved by CDC:

1. Name of Contractor: *Who is the contractor?* Identify the name of the proposed contractor and indicate whether the contract is with an institution or organization.
2. Method of Selection: *How was the contractor selected?* State whether the contract is sole source or competitive bid. If an organization is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract services.
3. Period of Performance: *How long is the contract period?* Specify the beginning and ending dates of the contract.
4. Scope of Work: *What will the contractor do?* Describe in outcome terms, the specific services/tasks to be performed by the contractor as related to the accomplishment of program objectives. Deliverables should be clearly defined.
5. Method of Accountability: *How will the contractor be monitored?* Describe how the progress and performance of the contractor will be monitored during and on close of the contract period. Identify who will be responsible for supervising the contract.
6. Itemized Budget and Justification: Provide an itemized budget with appropriate justification. If applicable, include any indirect cost paid under the contract and the indirect cost rate used.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

# Program Evaluation Guidance

## Introduction

The Evaluation and Program Effectiveness Team (EPET) is part of the Applied Research and Evaluation Branch of CDC's Division for Heart Disease and Stroke Prevention (DHDSP). EPET members are assigned to funded state programs and provide a range of evaluation technical assistance activities. EPET looks forward to working with you on your state evaluation activities.

The goals of EPET are to:

1. Provide timely evaluation technical assistance to CDC-funded state health departments as they undertake required evaluation tasks.
2. Promote and support the use of appropriate evaluation methods to improve program effectiveness.

This Welcome Packet provides important information about DHDSP and the evaluation technical assistance offered to states. The packet includes:

- An overview of the National Heart Disease and Stroke Prevention (HDSP) Program.
- Evaluation requirements of the current funding opportunity announcement (FOA).
- A list of current evaluation technical assistance available to state programs.
- A list of resources that can help you plan and implement your program evaluation activities.

As you begin evaluation work with your state program, EPET is available to assist you. A list of EPET members assigned to states is included in this packet so that you can become familiar with your EPET evaluation contact. EPET will work in collaboration with your state's assigned project officer to address your evaluation needs.

## Section 1: Announcement DP07-704 Evaluation Performance Measures

Announcement DP07-704 contains several requirements for evaluation. Performance measures for each year are listed in the FOA. All states are expected to engage in evaluation of their programs. At a minimum, all basic implementation (BI) states are expected to develop programmatic logic models and evaluation plans for at least one intervention or project. States also are expected to report program progress in the HDSP Management Information System (MIS).

The next two pages contain lists of performance measures that are specific to evaluation and their respective time frames for capacity building (CB) and BI HDSP programs.

## Section 2: The EPET Evaluation Technical Assistance Services

### Evaluation Assistance Available to State Programs

EPET provides evaluation assistance to states through trainings, quarterly evaluation conference calls, one-on-one calls with states, an annual review of state evaluation activities, participation in site visits, and ad-hoc evaluation technical assistance. Each of these EPET services will be briefly reviewed.

### Trainings

EPET, in partnership with evaluation experts and contractors, offers a variety of evaluation training sessions as a part of the annual grantee meeting. EPET strives to deliver trainings that are relevant,

**Performance Measures Specific to Evaluation: Capacity Building and Basic Implementation Programs**

Evaluation Activity	Capacity Building	Basic Implementation
<b>Designate Evaluation Staff</b> .5 FTE or equivalent		X
<b>Logic Model</b> Develop an overall program logic model that graphically describes the relationship between program activities and expected outcomes and reflects program priorities. (See the HDSP Evaluation Guide Logic Models.)	X	X
<b>Develop an Overall Evaluation Plan</b> The evaluation plan should include process and outcome evaluation to assess effectiveness and potential impact of the intervention/project (BI) or partnership (CB).	X	X
<b>Use of the Management Information System (MIS)</b> Use the HDSP MIS to track progress toward achieving HDSP work plan objectives.	X	X
<b>Core Indicators</b> Report on comprehensive and core indicators as they become available.	X	X
By the End of Year 1:		
Complete a training needs assessment of staff and partners. Develop and implement a training plan based on the needs assessment.		X
By the End of Year 2:		
Complete a training needs assessment. Develop and implement a training plan to increase the capacity of staff and partners.	X	
Implement and initiate evaluation of at least two population-based policy/systems change interventions to control high blood pressure and/or high blood cholesterol in the health care or worksite setting. Priority Populations should be considered.		X
Evaluate the state partnership, including its effectiveness in leveraging resources and implementing interventions.		X
By the End of Year 3:		
Evaluate the state partnership, including, for example, partner satisfaction, commitment and involvement, infrastructure and functioning, effectiveness and outcomes, and sustainability.	X	
Implement and initiate evaluation of at least one additional population-based policy/systems change intervention strategy in one of the remaining program priority areas (quality of care [other than high blood pressure or high cholesterol], emergency response, signs and symptoms in the health care or worksite setting).		X
By the End of Year 4:		
Document continued progress on implementing and evaluating population-based interventions using the MIS.		X
Evaluate interventions among Priority Populations and use evaluation findings for program improvement. Submit a brief summary of intervention evaluation findings that includes an improvement plan.		X
By the End of Year 5:		
Implement and initiate evaluation of a small-scale version of at least one of the population-based interventions proposed in year 4.	X	
Evaluate interventions among Priority Populations.		X

timely, and useful. Examples of evaluation trainings that EPET has offered in the past include:

- Strengthening and evaluating state partnerships.
- Developing logic models.
- Economic evaluation.
- Using evaluation indicators.
- Questionnaire and survey design.
- The intersection between epidemiology and evaluation.
- Developing an evaluation plan.
- Needs assessment using qualitative data collection methods.
- Software tools for program evaluation.
- Evaluation strategies for media campaigns.

### Quarterly Evaluation Conference Calls

In partnership with the Program Services Team, EPET offers quarterly telephone conference calls focused

on evaluation topics. These calls often address upcoming evaluation requirements of the cooperative agreement. The list of calls is sent annually.

### Scheduled One-on-One Calls with States

EPET participates in a variety of one-on-one calls with states, including:

- **Introductory evaluation call** during monthly project officer call: This call includes a 15-minute introduction to your EPET primary evaluation contact and a brief explanation of the evaluation technical assistance that will be provided for your state.
- **Evaluation-specific technical assistance** during monthly project officer call: Project officers and EPET staff will work together to connect you to the EPET staff person assigned to your state (see Appendix B for EPET staff assignments) and further explain evaluation measures and available evaluation technical assistance and trainings. In addition, time will be allocated during the monthly calls to discuss program evaluation-related areas at least once a year.

### Performance Measures Specific to Evaluation: Stroke Network Programs

Evaluation Activity
By the End of Year 2:
Develop an evaluation strategy that will be used to assess the selected activities.
By the End of Year 3:
<ul style="list-style-type: none"> <li>• Provide evidence of the implementation of uniform policy and systems change activities across the region.</li> <li>• Demonstrate the effectiveness of stroke network structure and partnerships.</li> <li>• Use network data to engage stakeholders in promoting policy and systems change activities. Promote stroke network accomplishments through such means as reports, journal articles, presentations, best practices, and websites.</li> <li>• Evaluate stroke network impact on the regional stroke burden, statewide or organizational policies, or policy and decision makers.</li> </ul>

## Annual Review of State Evaluation Activities

EPET staff conduct a thorough annual review of each BI state's evaluation plan, logic model, MIS data, evaluation reports, and other relevant information related to its evaluation efforts. Findings are discussed with the CDC project officer, and states are provided with written feedback from the assessment, including recommendations and follow-up steps.

## Participation in Site Visits

At the request of a project officer or state staff, BI and CB Optional states can have their assigned EPET staff person join their project officer on a site visit. Time will be set aside on the site visit agenda for the EPET staff to provide technical assistance for interventions evaluated by the state.

Alternatively, for any state (BI, CB Optional, or CB), the assigned EPET staff person can participate in any portion(s) of the site visit pertaining to evaluation (e.g., update of evaluation activities, evaluation questions or concerns) via phone. EPET staff appreciate the opportunity to participate in site visits via phone to stay updated about the state's evaluation activities.

## Ad Hoc Evaluation Technical Assistance

EPET can provide evaluation technical assistance to states on an as-needed basis. Consultation is available for multiple evaluation topics and activities. For example, states can access individual technical assistance for help with:

- Designing an evaluation (where to start, what to evaluate).
- Deciding who to engage in evaluation activities (identifying evaluation stakeholders and intended users).
- Developing and prioritizing evaluation questions.
- Reviewing a state logic model or evaluation plan.
- Developing an evaluation protocol.
- Collecting and analyzing data.
- Determining ways to ensure use of evaluation results and share lessons learned.
- Conducting economic evaluations.

## How to Access Technical Assistance from EPET

Each state has been assigned EPET staff members. Your assigned EPET staff members will provide your state with evaluation technical assistance as needed. Appendix B provides state assignments for evaluation. As shown, each state is assigned a primary and secondary evaluation contact. The two evaluation contacts work together to ensure that states' evaluation needs are met. A state's primary point of contact for evaluation technical assistance is listed as the "evaluation contact."

Requests for technical assistance from EPET should include your project officer. Evaluation technical assistance can be accessed during the monthly calls with your project officer. In addition, EPET staff can be contacted via e-mail. Contact information for EPET staff is listed on the next page. **Please copy your project officer on any e-mails you send to your assigned EPET staff member.**

In addition to keeping your project officer informed of your contact with EPET staff, it is important to communicate this information to your state program manager.

*Please remember to copy your project officer when contacting your assigned EPET staff person for evaluation technical assistance.*

## Section 3: Evaluation Competencies for State HDSP Evaluators

State evaluators are expected to perform a range of evaluation activities for their programs. Evaluation requirements are noted in FOA 704 and in the list of performance measures specific to evaluation.

An evaluation competencies checklist was developed to help evaluators identify and build requisite skills. The checklist is for state HDSP program reference only and includes recommended competencies for state evaluators. It can be used to determine the

range of evaluation skills needed and to identify areas for improvement.

Remember, if you need assistance, your project officers and assigned EPET staff are available. This checklist can help you identify areas for which you may want to access technical assistance.

### Evaluation Competencies

The evaluator competencies checklist, on the following pages, is a list of specific evaluation skills that reflects DHDSP evaluation activities. This list of competencies is intended for state program staff who carry out evaluation activities.

### DHDSP Evaluation Competencies Checklist

#### Evaluation Approach

- Apply the CDC framework for program evaluation to evaluation projects.
  - Apply professional standards of feasibility, utility, accuracy, and propriety to evaluation work.
- Apply evaluation theory and models to evaluate:
  - Chronic disease prevention and control.
  - Policy and system change.
- Gather evidence through a review of scientific and other literature.

#### Evaluability Assessment

- Assess the readiness of an intervention or program to undergo a formal evaluation.
- Examine the stage of development of a program or strategy.
- Assess a program's capacity to collect evaluation data.
- Assess the level of rigor needed to begin an evaluation study.
- Identify the potential uses of results of a formal evaluation.

#### Cultural Competence

- Gain experience conducting evaluations in a variety of cultural settings.
- Apply principles of cultural appropriateness to evaluation design, methods, and procedures.

#### Interpersonal Communication Skills

- Communicate effectively using verbal and listening skills.
- Communicate with local, state, and national HDSP partners in the evaluation process.

#### Logic Modeling

- Develop a clear understanding of the program's purpose and objective.
- Articulate a program theory of change by displaying the key relationships among inputs, activities, outputs, and outcomes in a logic model.
- Ensure that an appropriate level of detail is included.
- Use a logic model for evaluation planning.

**DHDSP Evaluation Competencies Checklist** (continued)**Developing an Evaluation Plan**

- Frame evaluation questions to reflect program and stakeholder needs.
- Write SMART objectives (i.e., 1. Specific, 2. Measurable, 3. Achievable, 4. Realistic, 5. Time-limited).
- Link evaluation questions to appropriate evaluation designs.

**Conducting Process Evaluation**

- Describe, assess, monitor, and track components of the program using process indicators.
- Articulate how and why a program operates.
- Use information about inputs, activities, and outputs to support program improvement.

**Conducting Outcome Evaluation**

- Determine indicators to measure program success.
- Monitor program performance.

**Collecting, Analyzing, and Interpreting Evaluation Data**

- Identify and appropriately use public health data as an evaluation tool.
- Apply appropriate data collection methods for measuring intended evaluation questions.
- Collect and analyze qualitative data using appropriate methods.
- Collect and analyze quantitative data using basic statistical methods.

- Use statistical software, such as SPSS, SAS, Excel, and Access, to analyze program and evaluation data.
- Synthesize findings across evaluations.

**Evaluating State Partnerships**

- Develop a detailed evaluation plan for evaluating state partnerships.
- Design and implement a training needs assessment.

**Evaluation Reporting**

- Design appropriate evaluation communication strategies for intended audiences.
- Prepare a written report for varied internal and external audiences/partners.
- Prepare oral presentations for varied internal and external audiences/partners.
- Arrange or facilitate learning sessions and documents regarding evaluation results.

**Evaluation Utilization**

- Assess the feasibility of the evaluation recommendations.
- Ensure evaluation data are used in an ongoing way to inform program and evaluation planning.
- Link the evaluation to decision making.
- Maximize evaluation utility.

## Section 4: Evaluation Resources

Resources are available to assist with the evaluation of state programs. A series of evaluation guidance documents from DHDSP and a number of additional resources can help states conduct required evaluation activities. This chapter provides a list of useful evaluation resources.

### Evaluation Guidance Documents

EPET has developed a series of evaluation guidance documents intended to aid skill building on a wide range of general evaluation topics and selected specific topics. The documents were developed with the assumption that state health departments have varied experience with program evaluation and a range of resources allocated to program evaluation. These guides clarify approaches to and methods for evaluation, provide examples specific to the scope and purpose of state HDSP programs, and recommend resources for additional reading. Guides have been developed for the following topics:

- Writing SMART objectives.
- Developing and using a logic model.
- Developing an evaluation plan.
- Evaluating partnerships.

The guides are available online at [www.cdc.gov/DHDSP/state\\_program/evaluation\\_guides/index.htm](http://www.cdc.gov/DHDSP/state_program/evaluation_guides/index.htm).

States can learn more about DHDSP by visiting [www.cdc.gov/DHDSP/index.htm](http://www.cdc.gov/DHDSP/index.htm).

### Additional Evaluation Resources

The following resource list is divided by topic and includes links to valuable information from CDC and other national organizations.

### General Evaluation Sites

These sites provide a variety of evaluation tools, techniques, and resources.

CDC Evaluation Working Group  
[www.cdc.gov/eval](http://www.cdc.gov/eval)

University of Wisconsin - Extension Program  
Development and Evaluation  
[www.uwex.edu/ces/pdande](http://www.uwex.edu/ces/pdande)

Western Michigan University Evaluation Center  
[www.wmich.edu/evalctr](http://www.wmich.edu/evalctr)

W.K. Kellogg Foundation Evaluation Handbook  
<http://www.wkcf.org/knowledge-center/resources/2010/W-K-Kellogg-Foundation-Evaluation-Handbook.aspx>

### Evaluation Theory/Model/Approach

CDC's Framework for Program Evaluation in Public Health

[www.cdc.gov/eval/framework.htm](http://www.cdc.gov/eval/framework.htm)

*CDC State Heart Disease and Stroke Prevention Program Evaluation Framework*

[www.cdc.gov/DHDSP/library/evaluation\\_framework/index.htm](http://www.cdc.gov/DHDSP/library/evaluation_framework/index.htm)

### Evaluability Assessment

Wholey JS. Evaluability assessment. In: Wholey JS, Hatry HP, Newcomer KE, editors. *Handbook of practical program evaluation*. 2nd ed. San Francisco: Jossey-Bass; 2004. p. 33–61.

Thurston WE, Potvin L. Evaluability assessment: A tool for incorporating evaluation in social change programmes. *Evaluation* 2003;9(4):453–469.

### Cultural Competence

Hood S, Hopson R, Frierson H, editors. *The role of culture and cultural context: A mandate for inclusion, the discovery of truth, and understanding in evaluative theory and practice*. Greenwich, CT: Information Age Publishing; 2005.

## Logic Models

DHDSP Evaluation Guide: Developing and Using a Logic Model

[www.cdc.gov/DHDSP/state\\_program/evaluation\\_guides/pdfs/logic\\_model.pdf](http://www.cdc.gov/DHDSP/state_program/evaluation_guides/pdfs/logic_model.pdf)

W.K. Kellogg Foundation Logic Model Development Guide

<http://www.wkkf.org/knowledge-center/resources/2010/Logic-Model-Development-Guide.aspx>

## SMART Objectives

DHDSP Evaluation Guide: Writing SMART Objectives

[www.cdc.gov/DHDSP/state\\_program/evaluation\\_guides/smart\\_objectives.htm](http://www.cdc.gov/DHDSP/state_program/evaluation_guides/smart_objectives.htm)

## Conducting Evaluations

Introduction of Process Evaluation in Tobacco Use Prevention and Control

[www.cdc.gov/Tobacco/tobacco\\_control\\_programs/surveillance\\_evaluation/process\\_evaluation/index.htm](http://www.cdc.gov/Tobacco/tobacco_control_programs/surveillance_evaluation/process_evaluation/index.htm)

W.K. Kellogg Foundation Evaluation Handbook

<http://www.wkkf.org/knowledge-center/resources/2010/W-K-Kellogg-Foundation-Evaluation-Handbook.aspx>

NSF User-Friendly Handbook for Project Evaluation

[www.nsf.gov/pubs/2002/nsf02057/start.htm](http://www.nsf.gov/pubs/2002/nsf02057/start.htm)

## Data Collection, Analysis and Interpretation

Taylor-Powell E, Steele S. Collecting evaluation data:

An overview of sources and methods. Madison, WI: University of Wisconsin Extension; 1996. Available from URL: <http://learningstore.uwex.edu/pdf/G3658-4.pdf>.

Strauss A, Corbin J. Basics of qualitative research: Techniques and procedures for developing grounded theory. 2nd ed. Thousand Oaks, CA: Sage; 1998.

## Evaluating State Partnerships

DHDSP Evaluation Guide: Fundamentals of Evaluating Partnerships

[www.cdc.gov/DHDSP/state\\_program/evaluation\\_guides/evaluating\\_partnerships.htm](http://www.cdc.gov/DHDSP/state_program/evaluation_guides/evaluating_partnerships.htm)

## Evaluation Reporting

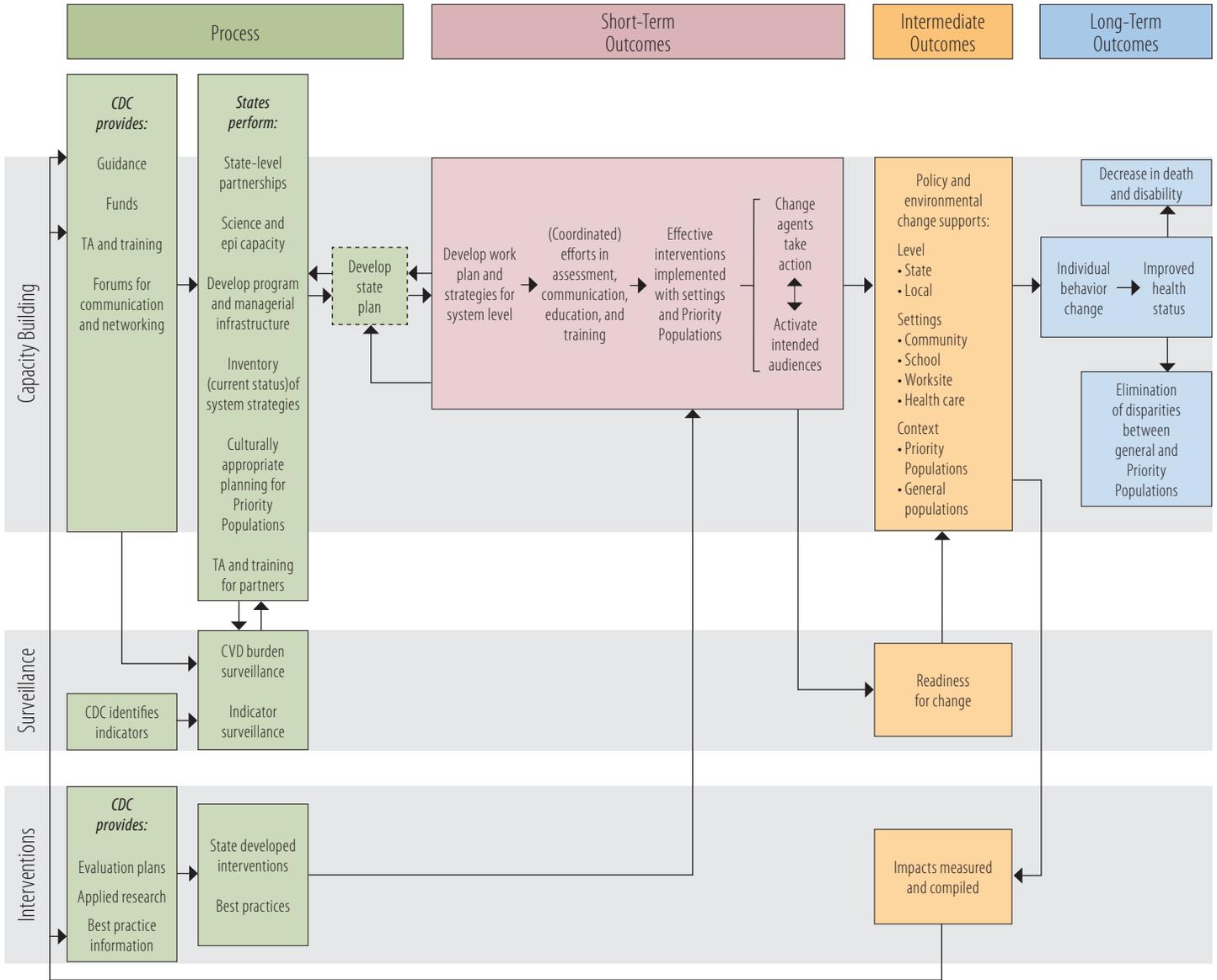
Torres RT, Preskill HS, Piontek ME. Evaluation strategies for communicating and reporting:

Enhancing learning in organizations. Sage: Thousand Oaks, CA; 2005.

## Evaluation Utilization

Patton MQ. Utilization focused evaluation: The new century text. Beverly Hills, CA: Sage; 1997.

### National HDSP Program Logic Model



DIVISION FOR HEART DISEASE AND STROKE PREVENTION

# Appendix: Websites, Publications, and Tools

## Important Websites

### **A Systematic Approach to State Heart Disease and Stroke Prevention Programs (Roadmap)**

[www.cdc.gov/dhdsp/roadmap/index.htm](http://www.cdc.gov/dhdsp/roadmap/index.htm)

The Roadmap is a Web-based resource for training and information to help build and carry out the competencies needed to develop and implement a National Heart Disease and Stroke Prevention (HDSP) program.

### **American Heart Association**

[www.heart.org](http://www.heart.org)

The American Heart Association is a national voluntary health agency whose mission is “Building healthier lives, free of cardiovascular diseases and stroke.” The website includes online tools, trainings, guidelines, and materials for use in a variety of settings and populations.

### **American Stroke Association**

[www.strokeassociation.org](http://www.strokeassociation.org)

The American Stroke Association is the division of the American Heart Association solely focused on reducing disability and death from stroke through research, education, fundraising, and advocacy. The website includes online tools, trainings, guidelines, and materials for use in a variety of settings and populations.

### **HHS Budget Regulations and Policy Guidance**

[www.hhs.gov/grantsnet/adminis/gpd/index.htm](http://www.hhs.gov/grantsnet/adminis/gpd/index.htm)

The Department of Health and Human Services (HHS) Grant Policy Statement provides to HHS grantees, in a single document, up-to-date policy guidance that serves as the administrative terms and

conditions of HHS discretionary grant awards. This document also is useful to those interested in HHS grant programs, providing information about HHS and its discretionary grant process.

### **CardioVascular Health Council**

[www.chronicdisease.org/i4a/pages/index.cfm?pageid=3597](http://www.chronicdisease.org/i4a/pages/index.cfm?pageid=3597)

The CardioVascular Health (CVH) Council comprises program managers and staff from state HDSP programs around the country as well as partnering agencies that support the work of HDSP programs. The Council provides a forum for managers and their staff to share their wisdom, experience, successes, and lessons learned to make their work more efficient and more effective. The Council is a component of the National Association of Chronic Disease Directors.

### **CVH Council—State Plans, Burden Reports, Links, and Documents**

[www.chronicdisease.org/i4a/pages/Index.cfm?pageID=3680](http://www.chronicdisease.org/i4a/pages/Index.cfm?pageID=3680)

This section of the CVH Council's website contains links to state plans, burden reports, websites, and other important documents for each state implementing an HDSP program.

### **Directors of Health Promotion and Education**

[www.dhpe.org](http://www.dhpe.org)

The membership of the Directors of Health Promotion and Education (DHPE) reflects a variety of state organizational structures and program emphases. One of DHPE's strengths is its ability to conduct programs in numerous public health areas that emphasize community-based prevention and health promotion/health education. DHPE focuses on policy, programs, training, and resources.

**CDC Division for Heart Disease and Stroke Prevention websites**

- [www.cdc.gov/dhdsp](http://www.cdc.gov/dhdsp)
- [www.cdc.gov/WISEWOMAN](http://www.cdc.gov/WISEWOMAN)  
(WISEWOMAN program)
- [www.cdc.gov/dhdsp/state\\_program/index.htm](http://www.cdc.gov/dhdsp/state_program/index.htm)  
(National Heart Disease and Stroke Prevention program)
- [www.cdc.gov/dhdsp/stroke\\_registry.htm](http://www.cdc.gov/dhdsp/stroke_registry.htm) (Paul Coverdell National Acute Stroke Registry)

**National Association of Chronic Disease Directors**

[www.chronicdisease.org/i4a/pages/index.cfm?pageid=1](http://www.chronicdisease.org/i4a/pages/index.cfm?pageid=1)

The National Association of Chronic Disease Directors (NACDD) links chronic disease program directors from each state and U.S. territory by providing a national forum for chronic disease prevention and control efforts. NACDD works to reduce the impact of chronic diseases on the American population by advocating for preventative policies and programs, encouraging knowledge sharing, and developing partnerships for health promotion.

**National Conference of State Legislatures**

[www.ncsl.org](http://www.ncsl.org)

The National Conference of State Legislatures (NCSL) is a bipartisan organization that serves the legislators and staffs of the nation's states, commonwealths, and territories. NCSL provides research, technical assistance, and opportunities for policy makers to exchange ideas on the most pressing state issues. NCSL is an effective advocate for the interests of state governments before Congress and federal agencies.

**National Heart Disease and Stroke Prevention annual training information**

[www.ora.gov/hsc/hdspinstitute/default.html](http://www.ora.gov/hsc/hdspinstitute/default.html)

**National Heart, Lung, and Blood Institute**

[www.nhlbi.nih.gov](http://www.nhlbi.nih.gov)

The National Heart, Lung, and Blood Institute provides global leadership for a research, training, and education program to promote the prevention and treatment of heart, lung, and blood diseases and enhance the health of all individuals so that they can live longer and more fulfilling lives.

**National Institutes of Health**

[www.nih.gov](http://www.nih.gov)

The National Institutes of Health (NIH), part of the U.S. Department of Health and Human Services, is the primary federal agency for conducting and supporting medical research. Composed of 27 Institutes and Centers, NIH provides leadership and financial support to researchers in every state and throughout the world.

**National Institute of Neurological Disorders and Stroke**

[www.ninds.nih.gov](http://www.ninds.nih.gov)

The National Institute of Neurological Disorders and Stroke conducts, fosters, coordinates, and guides research on the causes, prevention, diagnosis, and treatment of neurological disorders and stroke, and it supports basic research in related scientific areas.

**National Stroke Association**

[www.stroke.org](http://www.stroke.org)

The National Stroke Association (NSA) is a leading national resource on stroke and the driving force behind efforts to improve stroke prevention, treatment, and rehabilitation. NSA achieves its mission to lower the incidence and impact of stroke by developing compelling community outreach programs, calling for continued improvement in the quality of stroke patient care, and educating both health care professionals and the general public about stroke.

**WISE Interventions**

[www.wiseinterventions.org](http://www.wiseinterventions.org)

The WISE Interventions website is designed to provide WISEWOMAN program practitioners with effective interventions and best practices that help women prevent, delay, and control cardiovascular and other chronic diseases by eating healthy, increasing physical activity, and ceasing tobacco use. The site disseminates interventions, emerging tools, and best practice toolkits.

## Publications and Tools

**2010 Atlas of Heart Disease Hospitalizations Among Medicare Beneficiaries**

[http://www.cdc.gov/dhdsp/library/heart\\_atlas/index.htm](http://www.cdc.gov/dhdsp/library/heart_atlas/index.htm)

The *Atlas of Heart Disease Hospitalizations Among Medicare Beneficiaries* is the sixth in a series of CDC atlases on cardiovascular disease, and it is the second atlas focusing on cardiovascular-related hospitalizations in the Medicare population. Developed in collaboration with the Centers for

Medicare and Medicaid Services, it includes county-level maps of heart disease hospitalizations by heart disease subtype, race/ethnicity, and discharge status. Maps of hospital facilities and heart disease specialists also are included.

**2008 Atlas of Stroke Hospitalizations Among Medicare Beneficiaries**

[www.cdc.gov/dhdsp/library/stroke\\_hospitalization\\_atlas.htm](http://www.cdc.gov/dhdsp/library/stroke_hospitalization_atlas.htm)

The *Atlas of Stroke Hospitalizations Among Medicare Beneficiaries* is the fifth in a series of CDC atlases related to cardiovascular disease. Developed in collaboration with the Centers for Medicare and Medicaid Services, it includes county-level maps of stroke hospitalizations by stroke subtype, race/ethnicity, discharge status, and comorbidity.

**The Atlas of Heart Disease and Stroke**

[www.cdc.gov/dhdsp/library/cvd\\_atlas.htm](http://www.cdc.gov/dhdsp/library/cvd_atlas.htm)

*The Atlas of Heart Disease and Stroke* provides information about the global epidemic of heart disease and stroke for use by policy makers, national and international organizations, health professionals, and the general public. It was published jointly by CDC and the World Health Organization.

**Chronic Disease Cost Calculator**

[www.cdc.gov/dhdsp/announcements/cost\\_calculator.htm](http://www.cdc.gov/dhdsp/announcements/cost_calculator.htm)

The Chronic Disease Cost Calculator is a downloadable tool that provides state-level estimates of Medicaid expenditures for six chronic diseases. It also generates estimates of the costs to Medicaid of those diseases using customized inputs.

**Chronic Disease GIS Exchange**

<http://www.cdc.gov/dhdsp/maps/gisx>

Developed by CDC's Division for Heart Disease and Stroke Prevention, the Chronic Disease GIS Exchange provides a community forum to share maps and mapping techniques. Visitors can explore map galleries, share maps, access geographic information systems (GIS) training modules, learn tips from advanced users for creating maps, and access a wide range of GIS resources.

**Community Health Worker's Heart Disease and Stroke Prevention Sourcebook**

[www.cdc.gov/dhdsp/library/chw\\_sourcebook/index.htm](http://www.cdc.gov/dhdsp/library/chw_sourcebook/index.htm)

The *Community Health Worker's Heart Disease and Stroke Prevention Sourcebook* is the first comprehensive training manual to improve the skills and competencies of community health workers and other laypersons to help prevent heart disease and stroke among disparate populations. The sourcebook contains information and activities related to heart disease and stroke, including their major risk factors. It also addresses people's adherence to treatment and communication with health care providers.

**Data Set Directory of Social Determinants of Health at the Local Level**

[www.cdc.gov/dhdsp/library/data\\_set\\_directory](http://www.cdc.gov/dhdsp/library/data_set_directory)

The directory contains an extensive list of existing data sets that can be used to address social determinants. The data sets are organized according to 12 dimensions of the social environment.

**Data Trends & Maps**

[http://apps.nccd.cdc.gov/NCVDSS\\_DTM](http://apps.nccd.cdc.gov/NCVDSS_DTM)

Data Trends & Maps is an interactive online tool that allows users to search for and view health indicators related to heart disease and stroke prevention. The data are organized by location (national, state,

county, and selected sites) and indicator, and they include cardiovascular diseases (e.g., heart failure), risk factors (e.g., hypertension), and biomarkers (e.g., homocysteine). Data can be plotted as 10-year trends and stratified by age group, sex, and race/ethnicity.

**A Guide to Facilitating Health Systems Change**

[www.cdc.gov/dhdsp/library/guide\\_facilitating\\_hs\\_change.htm](http://www.cdc.gov/dhdsp/library/guide_facilitating_hs_change.htm)

The purpose of this guide is to help states facilitate changes in health care systems to improve prevention and management of heart disease and stroke and their risk factors. The guide was developed with the idea that state health departments can facilitate such changes by involving a diverse group of health care partners in assessing the state of heart disease and stroke prevention and management, identifying changes that are needed to improve the quality of care, and determining how best to make those changes.

**Heart Disease and Stroke Prevention Program Evaluation Guides**

[www.cdc.gov/dhdsp/state\\_program/evaluation\\_guides](http://www.cdc.gov/dhdsp/state_program/evaluation_guides)

The Heart Disease and Stroke Prevention Program Evaluation Guides are evaluation technical assistance tools developed by CDC's Division for Heart Disease and Stroke Prevention to assist in the evaluation of state heart disease and stroke prevention activities. The guides offer guidance, consistent definition of terms, and aid skill building on a wide range of general evaluation topics and selected specific topics.

**Heart Disease and Stroke Prevention Fact Sheets**

[www.cdc.gov/dhdsp/library/fact\\_sheets.htm](http://www.cdc.gov/dhdsp/library/fact_sheets.htm)

The fact sheets include information, statistics, data, warning signs, and links to other resources on heart disease and stroke topics, such as high cholesterol, high blood pressure, and heart failure.

**Heart-Healthy and Stroke-Free: A Social Environment Handbook**

[www.cdc.gov/dhdsp/library/seh\\_handbook/index.htm](http://www.cdc.gov/dhdsp/library/seh_handbook/index.htm)

This handbook is a tool for everyone working to create heart-healthy and stroke-free communities across America. Health advocates are recognizing that creating and sustaining healthy communities requires fundamental social change that goes far beyond the individual patient education approach of many traditional public health programs.

**Moving Into Action: Promoting Heart-Healthy and Stroke-Free Communities**

[www.cdc.gov/dhdsp/library/moving\\_into\\_action/index.htm](http://www.cdc.gov/dhdsp/library/moving_into_action/index.htm)

*Moving into Action* is a series of five publications outlining specific actions that governors, state legislators, local officials, employers, and health care leaders can take to raise awareness, promote healthy behaviors, and reduce risk associated with heart disease and stroke in their communities.

**Prevention Works: CDC Strategies for a Heart-Healthy and Stroke-Free America**

[www.cdc.gov/dhdsp/library/prevention\\_works/index.htm](http://www.cdc.gov/dhdsp/library/prevention_works/index.htm)

This document provides a snapshot of heart diseases and stroke prevention at CDC. It also includes information on the health and economic costs of chronic diseases to the nation and outlines CDC's prevention strategies.

**A Public Health Action Plan to Prevent Heart Disease and Stroke**

[www.cdc.gov/dhdsp/library/action\\_plan/index.htm](http://www.cdc.gov/dhdsp/library/action_plan/index.htm)

The purpose of the plan is to chart a course for CDC and collaborating public health agencies, all

interested partners, and the public at large to help in promoting achievement of national goals for preventing heart disease and stroke over the next 2 decades.

**A Purchaser's Guide to Clinical Preventive Services: Moving Science into Coverage**

[www.cdc.gov/dhdsp/library/purchasers\\_guide.htm](http://www.cdc.gov/dhdsp/library/purchasers_guide.htm)

This guide translates clinical guidelines and medical evidence, providing large employers with the information they need to select, define, and implement preventive medical benefits, such as colorectal cancer screening and tobacco use treatment.

**Successful Business Strategies to Prevent Heart Disease and Stroke Toolkit**

[www.cdc.gov/dhdsp/library/toolkit/index.htm](http://www.cdc.gov/dhdsp/library/toolkit/index.htm)

This document provides information, materials, and tools that state programs can reference and distribute to businesses, primarily through employer and professional organizations. The toolkit also helps state programs address cardiovascular health priority areas.

**Taking Action for Heart-Healthy and Stroke-Free States: A Communication Guide for Policy and Environmental Change**

[www.cdc.gov/dhdsp/library/heart\\_stroke\\_guide](http://www.cdc.gov/dhdsp/library/heart_stroke_guide)

*Taking Action for Heart-Healthy and Stroke-Free States* includes information to help health programs across the country reduce the disabling, costly, and growing national tragedy of heart disease and stroke.

For more information please contact Centers for Disease Control and Prevention  
1600 Clifton Road NE, Atlanta, GA 30333  
Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348  
E-mail: [cdcinfo@cdc.gov](mailto:cdcinfo@cdc.gov) • Web: [www.cdc.gov](http://www.cdc.gov) -  
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